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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1305 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/27/2024 9: 32 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 2/27/2024 9: 32 am ] 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, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1		2	SIGNATURE STATEMENT	
1	Gre	gg Malott	Y	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				
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	168, 636	-481, 897	0	8, 899	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	81, 172	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		70, 398		0	10.00
10.01	RURAL HEALTH CLINIC II	0		25, 159		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		-4, 863		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		3, 696		0	10.03
200.00	TOTAL	0	249, 808	-387, 507	0	8, 899	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/27/2024 9:32 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 616 EAST 13TH PO Box: 1.00 State: IN Zi p Code: 46996 2.00 City: WINAMAC 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 5.00 Subprovi der - IRF 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 N 15.00 WI NAMAC PULASKI MEMORIAL RHC -Hospital-Based Health Clinic - RHC 158527 99915 03/14/2018 0 15.01 15.01 NORTH JUDSON PULASKI MEMORIAL RHC -Hospital - Based Health Clinic - RHC 158528 99915 03/15/2018 0 N 15.02 15.02 N 1111 FRANCESVILLE Hospital-Based Health Clinic - RHC PULASKI MEMORIAL RHC -158554 99915 07/06/2020 15.03 15.03 0 KNOX MEDICAL 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2022 09/30/2023 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. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22. 01 22.01 Ν Ν for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 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.

Health Financial Systems PULASKI MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPITAL Provi der Co	CN: 15-1305	Period: From 10/0	1/2022	of For Workshe Part I	et S-2	
			To 09/3	0/2023	Date/Ti 2/27/20	me Prej 124 9:32	pared: 2 am
		1.00	2. 0	20	3. 0	)O	
23.00 Which method is used to determine Medicaid days on lines 24 a below? In column 1, enter 1 if date of admission, 2 if census if date of discharge. Is the method of identifying the days i reporting period different from the method used in the prior reporting period? In column 2, enter "Y" for yes or "N" for	days, or 3 n this cost cost		2 N		3. (	JO	23. 00
In-State Medicaio paid day	d Medicaid s eligible unpaid days	pai d days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med d	ther li cai d lays	
24.00 If this provider is an IPPS hospital, enter the	0 2.00	3.00	4. 00	5. 00	0 6	. 00	24. 00
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state	0 0		0		0		25. 00
Medicaid paid days in column 1, the in-state  Medicaid eligible unpaid days in column 2,  out-of-state Medicaid days in column 3, out-of-state  Medicaid eligible unpaid days in column 4, Medicaid  HMO paid and eligible but unpaid days in column 5.			J				20.00
, para and an agree and an arrange and a second and a		<b>'</b>			Date of		
26.00 Enter your standard geographic classification (not wage) stat	us at the be	eginning of t	1. ( ne	2	2. 0	)()	26. 00
cost reporting period. Enter "1" for urban or "2" for rural.  27.00 Enter your standard geographic classification (not wage) stat reporting period. Enter in column 1, "1" for urban or "2" for enter the effective date of the geographic reclassification i	rural. If a		t	2			27. 00
35.00 If this is a sole community hospital (SCH), enter the number effect in the cost reporting period.		SCH status in	Begi nr	o oi na:	Endi	na.	35.00
			1. (		2. 0		
36.00 Enter applicable beginning and ending dates of SCH status. Su of periods in excess of one and enter subsequent dates.	bscript line	e 36 for numb	er				36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the num is in effect in the cost reporting period.	ber of perio	ods MDH statu	S	0			37. 00
37.01 Is this hospital a former MDH that is eligible for the MDH traccordance with FY 2016 OPPS final rule? Enter "Y" for yes or instructions)							37. 01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH greater than 1, subscript this line for the number of periods enter subsequent dates.							38. 00
			1. (		Y/ 2. 0		
39.00 Does this facility qualify for the inpatient hospital payment hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), 1 "Y" for yes or "N" for no. Does the facility meet the milea accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Ente or "N" for no. (see instructions)	or (iii)? Er ge requireme	nter in colum ents in	me N n		N		39.00
40.00 Is this hospital subject to the HAC program reduction adjustm "N" for no in column 1, for discharges prior to October 1. En no in column 2, for discharges on or after October 1. (see in	ter "Y" for				N		40. 00
				1. 00	2. 00	3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for di	onnononti onc	to obono in		N	N		45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception fo pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt.	r extraordir	nary circumst	ances	N	N N	N N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? 48.00 Is the facility electing full federal capital payment? Enter Teaching Hospitals		•		N N	N N	N N	47. 00 48. 00
56.00 Is this a hospital involved in training residents in approved periods beginning prior to December 27, 2020, enter "Y" for y cost reporting periods beginning on or after December 27, 202 the instructions. For column 2, if the response to column 1 i involved in training residents in approved GME programs in th and are you are impacted by CR 11642 (or applicable CRs) MA d "Y" for yes; otherwise, enter "N" for no in column 2.	es or "N" fo O, under 42 s "Y", or if e prior year	or no in colu CFR 413.78(b) this hospita or penultima	nn 1. For (2), see al was ate year,	N			56.00

			AL HOSPITAL	N 45 4005		LIEU	of Form		
HOSPI T	FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der CC	CN: 15-1305	Peri od: From 10/01/2 To 09/30/2	2023	Workshee Part I Date/Tim 2/27/202	e Pre 4 9:3	pared
					-	1. OC		XI X 3. 00	
57. 00	For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete	reside n colum cost re e Works applic R 413.7 on dut	nts in approve n 1. If column porting period heet E-4. If c able. For cost 7(e)(1)(iv) a y, if the resp	d GME progra 1 is "Y", d ? Enter "Y" olumn 2 is " reporting p nd (v), rega onse to line	, is yes, ms trained id for yes or N", eriods rdless of 56 is "Y"	1. 00	2.00	3.00	57. (
	If line 56 is yes, did this facility elect cost reimble defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	comple	te Wkst. D-5.		s as	N			58. 59.
9.00	ALE COSTS CLAIMED OF THE 100 OF WOLKSHEET A? IT yes	s, comp	Tete WKSt. D-2	NAHE 413.89 Y/N	5 Worksheet Li ne #		Pass-Thr Qualifica Criteri	ation	39.1
				1 00	2.00		Code		
0.00	Are you claiming nursing and allied health education	(NAHE)	costs for	1. 00 N	2.00		3. 00		60.
.0.00	any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent (adjustment? Enter "Y" for yes or "N" for no in column	85? ( umn 1. CR) NAH	see If column 1						
		Y/N	I ME	Direct GME	IME		Di rect	GME	
		1.00	2.00	3. 00	4.00		5. 00		, .
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care					0. 00		0. 00	61. 61.
1. 02	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care								61.
1. 03	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care								61.
1 04	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.
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's								61.
1. 06	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								61.
	care or general surgery. (see Histructions)	Pro	ogram Name	Program Coc	le Unweight		Unweigh Direct FTE Cou	GME	
1 10	Of the ETEC in Line 41 OF check for each new according		1. 00	2.00	3. 00	2 00	4. 00		41
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column					0. 00		0.00	

ealth Financial Systems		MEMORI AL HOSPI TAL	CON 15 1005		u of Form CMS-2	
OSPITAL AND HOSPITAL HEALTH CARE COMM	PLEX IDENTIFICATION DA	ATA Provi der		Period: From 10/01/2022 To 09/30/2023		pared
					1.00	1
ACA Provisions Affecting the He 2.00 Enter the number of FTE residen	ts that your hospital	trained in this co		eriod for which	0.00	62.
your hospital received HRSA PCR .01 Enter the number of FTE residen during in this cost reporting p	ts that rotated from	a Teaching Health C		to your hospital	0.00	62.
Teaching Hospitals that Claim R .00 Has your facility trained resid "Y" for yes or "N" for no in co	ents in nonprovider s	ettings during this			N	63.
, 100 yes 60 10 100 110 110 es	amir i. II yes, compr	oto minos on timosag	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2. 00	3.00	-
Section 5504 of the ACA Base Ye				_		
period that begins on or after  .00 Enter in column 1, if line 63 i in the base year period, the nu resident FTEs attributable to r settings. Enter in column 2 th resident FTEs that trained in y of (column 1 divided by (column	s yes, or your facili mber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained resident n-primary care all nonprovider d non-primary care n column 3 the rati		0.00	0. 000000	64.
pr (corumn i divided by (corumn	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	Si te 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)			Upwai shtad	Unweighted	Datio (ed.	
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current		n Nonprovider Setti				
beginning on or after July 1, 2 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	0.0	0.00	0. 000000	66.
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPI		MEMORIAL HOSPITAL  ATA Provider (		eriod: rom 10/01/202:	eu of Form CMS-2 Worksheet S-2 2 Part I	
			To			
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
17.00 5	1. 00	2. 00	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)			0.00	O. C	0. 000000	87.00
(See Thistructions)						
Discours out to the state of th	- FV 2002 I DDC F' - I	D. L. 07 ED 400/E	10070 (1) 10	2000)	1. 00	
68.00 For a cost reporting period begi MAC to apply the new DGME formul (August 10, 2022)?	nning prior to Octob	oer 1, 2022, did you	obtain permissi	on from your		68.00
				1	00 2.00 3.00	
Inpatient Psychiatric Facility P	PS			1. (	50   2.00   3.00	
70.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		(IPF), or does it con	ntain an IPF sub	provi der? N	I	70.00
71.00 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	2004? Enter "Y" for cility train resident )(D)? Enter "Y" for	yes or "N" for s in a new teac yes or "N" for	no. (see hi ng no.	0	71.00
75.00 Is this facility an Inpatient Re	habilitation Facilit	y (IRF), or does it	contain an IRF	N	1	75.00
subprovider? Enter "Y" for yes 76.00 If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	the facility have a ing on or before Nov train residents in a r "Y" for yes or "N"	vember 15, 2004? Ente a new teaching progra for no. Column 3: I	er "Y" for yes o mm in accordance f column 2 is Y	r "N" for with 42	0	76.00
					1.00	
Long Term Care Hospital PPS					1.00	
80.00 Is this a long term care hospita 81.00 Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Ente	r N	80.00 81.00
85.00 Is this a new hospital under 42 86.00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider r yes and "N" for no	(excluded unit) unde	er 42 CFR Sectio			85. 00 86. 00
87.00 Is this hospital an extended neo 1886(d)(1)(B)(vi)? Enter "Y" for		e hospital classified	I under section		N	87.00
1.000(0)(1.7(0)(1.7)(1.7)(1.7)	, , , , , , , , , , , , , , , , , , , ,			Approved for Permanent Adjustment (Y/N) 1.00	Number of Approved Permanent Adjustments 2.00	
88.00 Column 1: Is this hospital appro amount per discharge? Enter "Y" 89. (see instructions)		no. If yes, complete		N		88. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co		Period: From 10/01/2022	u of Form CMS- Worksheet S-2 Part I	2
		1	o 09/30/2023	Date/Time Pro 2/27/2024 9:3	
		Wkst. A Line No.	Date	Approved Permanent Adjustment Amount Per Discharge	
0.00 0.1 4 .1611 00 4 4 4 4 4		1.00	2. 00	3. 00	00.00
19.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge.  Column 3: Enter the amount of the approved permanent adjustm TEFRA target amount per discharge.	s based. J period Irget amount	0.0	V	XIX	0 89.0
			1.00	2. 00	
Title V and XIX Services			1		l
0.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through the properties of the column.			N N	Y	90.00
full or in part? Enter "Y" for yes or "N" for no in the appl 2.00 Are title XIX NF patients occupying title XVIII SNF beds (du	icable column	l.	14	N .	92.00
instructions) Enter "Y" for yes or "N" for no in the applica 3.00 Does this facility operate an ICF/IID facility for purposes	ble column.	, ,	N	N	93.00
"Y" for yes or "N" for no in the applicable column.					
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.			N	N	94.00
5.00 If line 94 is "Y", enter the reduction percentage in the app 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
7.00 If line 96 is "Y", enter the reduction percentage in the app 8.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	iterns and res	idents post	0. 00 Y	0. 00 Y	97. 00 98. 00
column 1 for title V, and in column 2 for title XIX.  8.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.			Y	Y	98.0
8.02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98. 0
for title V, and in column 2 for title XIX.  8.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye			N 1	N	98. 0
for title V, and in column 2 for title XIX.  8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 0
in column 2 for title XIX.  8.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98. 0
column 2 for title XIX.  8.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.0
Rural Providers					1.05.0
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen	t Y		105. 00 106. 00
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column			N		107. 0
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instructi	you train I&R PF and/or IRF	s in an			
08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	,	dul e? See 42	N		108. 0
	Physi cal	Occupati onal	Speech	Respiratory	
09.00  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.	•				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C			u of Form CMS	
	F	eriod: rom 10/01/2022 o 09/30/2023	Date/Time Pr	epared:
			2/27/2024 9:	32 am
110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable.	"N" for no. I	f yes,	1. 00 N	110.00
		1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier ( Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N N	2.00	111.00
	1.00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00 ls this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117. 00
118.00 st the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				118.00
	Premi ums	Losses	Insurance	
	1. 00	2. 00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:	195, 660	0		0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of		1. 00 N	2. 00	118. 02
and amounts contained therein.				110.02
and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless program in Sal21 and applicable amendments? (see instructions) Enter in column 1, "\" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instance)	" for yes or the Outpatient	N	N	119.00
119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "N "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instender in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices.	The Outpatient cructions)	N Y	N	119. 00 120. 00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\ "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.	" for yes or the Outpatient cructions) es charged to B(w)(3) of the	N Y N	N	119. 00 120. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "N" N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instender in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.</li> <li>If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organization? In column 2, enter "N" for no.</li> </ul>	"" for yes or the Outpatient cructions) es charged to 8(w)(3) of the er in column 2 sional and/or 1, enter "Y"		N Y	119. 00 120. 00 121. 00 122. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\"N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instener in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.</li> <li>Certified Transplant Center Information</li> <li>125.00 Does this facility operate a Medicare-certified transplant center? Enter</li> </ul>	"" for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" in 50% of total ganizations 'Y" for yes or	N	Y	119. 00 120. 00 121. 00 122. 00 123. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instended in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organization accepted in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.</li> <li>125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare-certified kidney transplant program, enter the certification.</li> </ul>	"" for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" 150% of total ganizations "Y" for yes or "Y" for yes	N Y	Y	119. 00 120. 00 121. 00 122. 00 123. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for thold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organization accounting to the main hospital CBSA? In column 2, enter "N" for no.</li> <li>Certified Transplant Center Information</li> <li>125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare-certified kidney transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare-certified heart transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.</li> </ul>	"" for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 sional and/or in 1, enter "Y" in 50% of total panizations Y" for yes or "Y" for yes cification date	N Y	Y	119.00 120.00 121.00 122.00 123.00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "N" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for thold Harmless provision in ACA §3121 and applicable amendments? (see instended that Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.</li> <li>If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.</li> <li>Certified Transplant Center Information</li> <li>125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare-certified kidney transplant program, enter the certific column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare-certified heart transplant program, enter the certific column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare-certified liver transplant program, enter the certification of the column 1 and termination date, if applicable, in column 2.</li> </ul>	"" for yes or the Outpatient cructions) es charged to se charged to se charged to se in column 2 sional and/or 1, enter "Y" 150% of total ganizations "Y" for yes or "Y" for yes crification date fication date	N Y	Y	119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instended that the Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain heal thcare related taxes as defined in \$1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.</li> <li>If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.</li> <li>Certified Transplant Center Information</li> <li>125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare-certified kidney transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare-certified heart transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.</li> </ul>	"" for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" 150% of total ganizations "Y" for yes or "Y" for yes cification date fication date	N Y	Y	119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00 128. 00

	EX IDENTIFICATION DATA	Provi der CCI	N: 15-1305		0/01/2022 9/30/2023	Worksheet S- Part I Date/Time Pr 2/27/2024 9:	epared:
					1. 00	2. 00	
31.00 If this is a Medicare-certified in			certi fi cati	on			131.00
date in column 1 and termination of 32.00 If this is a Medicare-certified is in column 1 and termination date,	slet transplant program,	enter the certif	fication da	te			132. 00
33.00 Removed and reserved							133. 00
34.00 If this is a hospital-based organ in column 1 and termination date, All Providers			ne OPO numb	er			134. 00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1. I e home office chain numbe	f yes, and home er. (see instruct	office cos	ts	N		140. 00
1.00 If this facility is part of a cha		00	ugh 142 +hc	nomo on	3. 00	of the home	
office and enter the home office	contractor name and contr	n fines 141 throu ractor number.	ugn 143 the	е паше ап	iu auui ess	of the nome	
41. 00 Name:	Contractor's Name:		Contrac	tor's Nu	mber:		141.00
42.00 Street: 43.00 Ci ty:	PO Box: State:		7in Cod	0.			142.00
43. 00 C  Ty.	state.		Zi p Cod	e.			143.00
						1. 00	
44.00 Are provider based physicians' cos	sts included in Worksheet	t A?				Υ	144. 00
					1. 00	2. 00	$\dashv$
45.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N"	' for yes or "N" for no i clude Medicare utilizatio	n column 1. If o	column 1 is				145. 00
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	column 1. (See CMS Pub.			lf	N		146.00
47 00		IINII 6			•	1.00	147.00
47.00 Was there a change in the statisti						N	
47.00 Was there a change in the statisti 48.00 Was there a change in the order of 49.00 Was there a change to the simplifi	f allocation? Enter "Y" f	for yes or "N" fo	or no.	or no.			148. 00
48.00 Was there a change in the order of	f allocation? Enter "Y" f	for yes or "N" fo Enter "Y" for ye Part A	or no. es or "N" f Part B	Ti	itle V	N N N Title XIX	148. 00
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48.00 Was there a change in the order of 49.00 Was there a change to the simplifi	f allocation? Enter "Y" fed cost finding method?	for yes or "N" for yes  Part A  1.00  an exemption from	or no. es or "N" f Part B 2.00 m the appli	cation o	3.00 f the low	N N N Title XIX 4.00 er of costs	148.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplification of the simplification	f allocation? Enter "Y" fed cost finding method?	for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the for Part A N N	or no. es or "N" f Part B 2.00 m the appli and Part E N	cation o	3.00 of the low 2 CFR §41: N	N N N Title XIX 4.00 er of costs 3.13) N N	148. 00 149. 00 155. 00 156. 00
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48.00 Was there a change in the order of 49.00 Was there a change to the simplification of the simplification	f allocation? Enter "Y" f ed cost finding method?  ider that qualifies for a "N" for no for each compo	For yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the part A N N N N N N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part B N N N N N S uses in dif	cation o s. (See 4	3.00 If the lowe 2 CFR §41: N N N N N S BSAs?	N N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N	147. 00 148. 00 149. 00 155. 00 156. 00 157. 00 159. 00 160. 00 161. 00
48.00 Was there a change in the order of 49.00 Was there a change to the simplification of 49.00 Was there a change to the simplification of the simplific	f allocation? Enter "Y" f ed cost finding method?  ider that qualifies for a "N" for no for each compo	For yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the part A N N N N N N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part B N N N N N S uses in dif	cation o s. (See 4	3.00 If the lowe 2 CFR §41: N N N N N S BSAs?	N N N N 4.00 er of costs 3.13) N N N N N N N T.00 N FTE/Campus 5.00	148. 00 149. 00 155. 00 156. 00 157. 00 159. 00 160. 00 161. 00
48.00 Was there a change in the order of 49.00 Was there a change to the simplification of 49.00 Was there a change to the simplification of the simplific	ampus hospital that has contained that Qualifies for a Name O	For yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from Part A N N N N N N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part B N N N N S State Z 2.00	ferent Cl	3.00 If the lowe 2 CFR §41: N N N N N S BSAs?	N N N N 4.00 er of costs 3.13) N N N N 1.00 N FTE/Campus 5.00 O.C	148. 0C 149. 0C 155. 0C 156. 0C 157. 0C 158. 0C 160. 0C 161. 0C
48.00 Was there a change in the order of 49.00 Was there a change to the simplification of 49.00 Was there a change to the simplification of 49.00 Was there a change to the simplification of 49.00 Was there a change to the simplification of 49.00 Was there a change to the simplification of 49.00 Was this facility of 49.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 Subprovider - IRF 58.00 Subprovider - IRF 58.00 Subprovider - IRF 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC  Multicampus  65.00 Is this hospital part of a Multication of 50.00 Was the formula of	ampus hospital that has contained by the second of the sec	For yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from Part A N N N N N N N N N N N N N N N N N N	or no. es or "N" f  Part B  2.00 m the appli and Part E  N N N N S  uses in dif  State Z 2.00  d Reinvestm 'N" for no.	ferent Cl	3.00 If the lowe 2 CFR §41. N N N N N S BSAS?  CBSA 4.00	N N N N 4.00 er of costs 3.13) N N N N N N N T.00 N FTE/Campus 5.00	148. 0C 149. 0C 155. 0C 156. 0C 157. 0C 159. 0C 160. 0C 161. 0C

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	TIFICATION DATA	Provider CCN: 15-1305	Peri od: From 10/01/2022	Worksheet S-2 Part I	!
			To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginni period respectively (mm/dd/yyyy)			170. 00		
			1.00	2. 00	
171.00 f line 167 is "Y", does this provider has section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1.	N on	0	171. 00		
1876 Medicare days in column 2. (see ins	structions)				

Hoal th	Financial Systems PULASKI MEMORI	AL HOSDITAL		In lie	u of Form CMS-	2552_10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 10/01/2022	Worksheet S-2	
				To 09/30/2023	Date/Time Pre	
	<u> </u>			Y/N	2/27/2024 9:3 Date	32 am
				1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	esponses. Ent	er all dates in	the	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation					1
1. 00	Has the provider changed ownership immediately prior to the			N N		1.00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions Y/N	) Date	V/I	
			1.00	2.00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F	rogram? If	N			2.00
	yes, enter in column 2 the date of termination and in colum	nn 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	na management	l N			3.00
0.00	contracts, with individuals or entities (e.g., chain home of		''			0.00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other lationships? (see instructions)	er Similar				
	Trender distributions,		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
4 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Dublic	У	A	Ī	4.00
4. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		, Y	A		4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	_				
5. 00	Are the cost report total expenses and total revenues differenthese on the filed financial statements? If yes, submit rec		N			5. 00
	those on the fired financial statements: If yes, submit rec	CONCLITIATION.		Y/N	Legal Oper.	
				1. 00	2.00	
,	Approved Educational Activities				Г	
6. 00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, I	s the provide	r N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in	structi ons.		N		7.00
8.00	Were nursing programs and/or allied health programs approve	ed and/or rene	wed during th	e N		8. 00
0.00	cost reporting period? If yes, see instructions.	araduata madi	aal adwaatian	N		0.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		car education	N		9.00
10.00	Was an approved Intern and Resident GME program initiated of		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.00
	Treaching Frogram on worksheet A: IT yes, see This tructions.				Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost roporting	Y	12.00
13.00	period? If yes, submit copy.	officy change	duiling this c	ost reporting	IN IN	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsura	nce amounts w	aived? If yes	, see	N	14.00
	instructions.					
15 00	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	ves see ins	tructions	N	15. 00
13.00	bru total beus avairable change from the birdi east reporti		t A		t B	13.00
		Y/N	Date	Y/N	Date	
	DC4D Data	1. 00	2. 00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Υ	01/08/2024	Y	01/08/2024	16.00
	If either column 1 or 3 is yes, enter the paid-through	·	01,00,2021	·	017 007 202 1	10.00
	date of the PS&R Report used in columns 2 and 4 .(see					
17. 00	instructions) Was the cost report prepared using the PS&R Report for	N		N		17. 00
17.00	totals and the provider's records for allocation? If	IN		IN		17.00
	either column 1 or 3 is yes, enter the paid-through date					
40.05	in columns 2 and 4. (see instructions)					10.00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	The small on: 11 yes, see that detrons.		I	ı	I	1

Heal th	Financial Systems PULASKI MEMOR	I AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1305	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II	epared:
			i pti on	Y/N	Y/N	
20.00	1611 47 47 17 18 18 18 18 18 18 18 18 18 18 18 18 18		0	1.00	3. 00	00.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	report data for other. Beserve the other day astments.	Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)	I		
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	ing the cost	N	23. 00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter If yes, see instructions	eporting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	? If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	the cost report	ing period?	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	ne cost reporti	ng period? I	f yes, submit	N	27. 00
28. 00	Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cos	t reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service I	Reserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	s, see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without instructions.	ssuance of new	debt? If yes	s, see	N	31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-l	pased physicians?	Υ	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office	N ?		36. 00 37. 00
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home of			f		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.			5,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see			40. 00
	1					
		2.	00			
44 05	Cost Report Preparer Contact Information	MI OLIAET		A1 E00A1251 111		1 44 22
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI		41.00
42. 00	Enter the employer/company name of the cost report preparer.	BLUE AND CO.,	LLC			42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7959		MALESSANDRI NI @I	BLUEANDCO. COM	43.00

Health Financial Systems PULASKI MET	MORIAL HOSPITAL	In Lieu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1305	Period: Worksheet S- From 10/01/2022 Part II To 09/30/2023 Date/Time Pr	epared:
		2/27/2024 9:	32 am
	3. 00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	DI RECTOR		41.00
held by the cost report preparer in columns 1, 2, and 3	,		
respecti vel y.			
42.00 Enter the employer/company name of the cost report			42.00
preparer.			
43.00 Enter the telephone number and email address of the cos	t		43.00
report preparer in columns 1 and 2, respectively.			

| Period: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: 
 Heal th Financial
 Systems
 PULASKI

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

					Ť	o 09/30/2023	Date/Time Pre 2/27/2024 9:3	
							I/P Days /	2 4111
							0/P Visits /	
							Trips	
	Component	Worksheet A	No. of E	Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No. 1.00	2. 00		Avai I abl e 3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA	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	19, 848. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and				., .==	,		
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider						0	4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						0	5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 125	19, 848. 00	0	
7.00	beds) (see instructions)			23	7, 123	17, 040. 00	U	7.00
8. 00	INTENSIVE CARE UNIT	31.00		0	0	0.00	0	8.00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			25	9, 125	19, 848. 00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits							15. 10
16. 00 17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF							16. 00 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	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00 26. 00	CMHC - CMHC	00.00					0	25.00
26. 00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	88. 00 88. 01					0	26. 00 26. 01
26. 01	RURAL HEALTH CLINIC III	88. 02					0	
26. 03	RURAL HEALTH CLINIC IV	88. 03					0	26.03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	1
27.00	Total (sum of lines 14-26)			25				27.00
28.00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33.00
	Temporary Expansion COVID-19 PHE Acute Care	30.00		0	O		0	
		,	'	-1		1		

Heal th FinancialSystemsPULASKIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					2/27/2024 9: 32 am			
		I/P Days	s / O/P Visits	/ Tri ps	Full Time I	Equi val ents		
	Component	Title XVIII	Title XIX	Total All	Total Interns			
		4 00	7.00	Patients	& Residents	Payrol I		
	DADT I CTATICTICAL DATA	6. 00	7. 00	8. 00	9. 00	10.00		
1 00	PART I - STATISTICAL DATA	345		801			1.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	345	6	801			1.00	
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)	90	16				2.00	
3. 00	HMO I PF Subprovi der	0	0				3.00	
4. 00	HMO IRF Subprovider	o	0				4.00	
5.00	Hospital Adults & Peds. Swing Bed SNF	353	0	353			5.00	
6.00	Hospital Adults & Peds. Swing Bed NF		0	169			6.00	
7.00	Total Adults and Peds. (exclude observation	698	6	1, 323			7.00	
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	0	0	0			8. 00	
9.00	CORONARY CARE UNIT						9. 00	
10.00	BURN INTENSIVE CARE UNIT						10.00	
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00	
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00	NURSERY		0				13.00	
14.00	Total (see instructions)	698	6		0. 00	185. 39	1	
15.00	CAH visits	0	0	0			15.00	
15. 10	REH hours and visits						15. 10	
16.00	SUBPROVIDER - I PF						16.00	
17. 00 18. 00	SUBPROVI DER						17. 00 18. 00	
19. 00	SKILLED NURSING FACILITY						19.00	
20.00	NURSING FACILITY						20.00	
21. 00	OTHER LONG TERM CARE						21.00	
22. 00	HOME HEALTH AGENCY	0	0		0. 00	0.00	•	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	o o	O		0.00	0.00	23.00	
24. 00	HOSPI CE	0	0		0. 00	0.00	•	
24. 10	HOSPICE (non-distinct part)		_				24. 10	
25. 00	CMHC - CMHC						25. 00	
26.00	RURAL HEALTH CLINIC	5, 663	6, 624	24, 983	0.00	46. 63	26.00	
26. 01	RURAL HEALTH CLINIC II	1, 297	622	4, 352	0.00	2. 45	26. 01	
26. 02	RURAL HEALTH CLINIC III	363	225	1, 482	0.00	2. 10	26. 02	
26.03	RURAL HEALTH CLINIC IV	1, 048	1, 032	4, 472	0.00	4. 37	26. 03	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	26. 25	
27.00	Total (sum of lines 14-26)				0.00	240. 94		
28. 00	Observation Bed Days		48	624			28. 00	
29. 00	Ambul ance Trips	0					29. 00	
30.00	Employee discount days (see instruction)			0			30.00	
31. 00	Employee discount days - IRF			0			31.00	
32. 00	Labor & delivery days (see instructions)	0	0				32.00	
32. 01	Total ancillary labor & delivery room			C			32. 01	
00.60	outpatient days (see instructions)						00.00	
33.00	LTCH non-covered days	0					33.00	
33. 01	LTCH site neutral days and discharges	0	^				33. 01	
34.00	Temporary Expansion COVID-19 PHE Acute Care	l O	0	0			34.00	

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: 
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-1305

Full Time   Equivalents   Nonpaid   Title V   Title XVIII   Title XIX   Total All   Patients   Title V   Title XVIII   Title XIX   Total All   Patients   Title V   Title XVIII   Title XIX   Total All   Patients   Title XIX   Total All   Title XIX   Total All   Title XIX   Total All   Patients   Title XIX   Total All   Patients   Title XIX   Total All   Patients   Title XIX   Total All   Title XIX   To
Equi val ents
PART I - STATISTICAL DATA
PART I - STATISTICAL DATA   1.00   12.00   13.00   14.00   15.00     1.00     12.00     13.00     14.00     15.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00     1.00   1.00   1.00   1
PART I - STATISTICAL DATA
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults & Peds. Swing Bed NF 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 15.10 REH hours and visits 15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 NURSING FACILITY 20.00 NURSING FACILITY
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMM and other (see instructions) 3.00 HMM IPF Subprovider 4.00 HMM IPF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 BURN INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.10 REH hours and visits 15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 SIMPROVIDER - 2.00
Hospice days)(See instructions for col. 2   for the portion of LDP room available beds)
For the portion of LDP room available beds   2.00
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 5.00 Hospi tal Adults & Peds. Swing Bed SNF 6.00 Hospi tal Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSI VE CARE UNIT 11.00 SURGICAL INTENSI VE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 9.00 CAH visits 15.00 CAH visits 15.00 CAH visits 15.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SVILLED NURSI NG FACILITY 20.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 SVILLED NURSI NG FACILITY 20.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 SVIBPROVIDER - IPF 20.00 NURSI NG FACILITY
3. 00
4.00
5.00
6.00   Hospital Adults & Peds. Swing Bed NF   7.00   Total Adults and Peds. (exclude observation beds) (see instructions)   8.00   INTENSIVE 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   15.00   CAH visits   15.10   CAH visits   15.10   16.00   SUBPROVIDER - IPF   17.00   SUBPROVIDER - IRF   18.00   19.00   SKILLED NURSING FACILITY   19.00   19.00   SKILLED NURSING FACILITY   19.00   19.00   NURSING FACILITY   20.00   NURSING FACILITY   20.00   10.00
7. 00   Total Adults and Peds. (exclude observation beds) (see instructions)   7. 00   8. 00   INTENSIVE CARE UNIT   8. 00   9. 00   10. 00   BURN INTENSIVE CARE UNIT   10. 00   11. 0
Beds) (see instructions)
8. 00   INTENSIVE CARE UNIT
9. 00 10. 00 BURN INTENSIVE CARE UNIT 10. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 13. 00 Total (see instructions) 14. 00 Total (see instructions) 15. 00 CAH visits 15. 10 REH hours and visits 15. 10 REH PROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00
10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 10.00 Total (see instructions) 10.00 0 100 2 230 14.00 15.00 CAH visits 15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00
11. 00   SURGI CAL INTENSIVE CARE UNIT   12. 00   12. 00   13. 00   14. 00   Total (see instructions)   0. 00   0   100   2   230   14. 00   15. 00   CAH visits   15. 10   REH hours and visits   15. 10   SUBPROVI DER - I PF   16. 00   17. 00   SUBPROVI DER - I RF   18. 00   18. 00   SKI LLED NURSI NG FACI LI TY   19. 00   20. 00   NURSI NG FACI LI TY   20. 00   NURSI NG FACI LI TY   20. 00   NURSI NG FACI LI TY   19. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   12. 00   13. 00   14. 00   12. 00   15. 10
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 15.10 REH hours and visits 16.00 SUBPROVIDER - I PF 17.00 SUBPROVIDER - I RF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY
13.00 NURSERY  14.00 Total (see instructions)  15.00 CAH visits  15.00 REH hours and visits  15.10 SUBPROVI DER - I PF  17.00 SUBPROVI DER - I RF  18.00 SUBPROVI DER  19.00 SKI LLED NURSI NG FACI LI TY  20.00 NURSI NG FACI LI TY  13.00  14.00  15.00  15.00  15.10  16.00  17.00  18.00  19.00  19.00  10.
15. 00 CAH visits
15. 00 CAH visits
16. 00   SUBPROVI DER - I PF   16. 00   17. 00   SUBPROVI DER - I RF   18. 00   18. 00   SUBPROVI DER   18. 00   19. 00   SKILLED NURSI NG FACILITY   19. 00   20. 00   NURSI NG FACILITY   20. 00   SKILLED NURSI NG FACILITY   20. 00
17. 00   SUBPROVI DER - I RF   17. 00   18. 00   19. 00   SKI LLED NURSI NG FACI LI TY   19. 00   20. 00   NURSI NG FACI LI TY   20. 00
18. 00   SUBPROVI DER   18. 00   19. 00   SKI LLED NURSI NG FACI LI TY   20. 00   NURSI NG FACI LI TY   20. 00
19.00   SKILLED NURSING FACILITY   19.00   20.00   NURSING FACILITY   20.00
20. 00 NURSING FACILITY 20. 00
21.00 OTHER LONG TERM CARE     21.00
00 00 11005 1150 711 405007
22. 00 HOME HEALTH AGENCY 0. 00 22. 00
23. 00   AMBULATORY SURGI CAL CENTER (D. P. )   23. 00   24. 00   HOSPI CE   0. 00   24. 00
24. 00   HOSPI CE   0. 00   24. 10   24. 10   HOSPI CE (non-distinct part)   24. 10
24. 10 HOSPICE (HOIT-district part) 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 111   0.00   26.02
26. 03   RURAL HEALTH CLINIC I V 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
29.00 Ambul ance Tri ps 29.00
30.00 Employee discount days (see instruction) 30.00
31.00 Employee di scount days - IRF
32.00 Labor & delivery days (see instructions) 32.00
32.01 Total ancillary labor & delivery room 32.01
outpatient days (see instructions)
33.00 LTCH non-covered days 0 33.00
33.01 LTCH site neutral days and discharges 0 33.01
34.00   Temporary Expansion COVID-19 PHE Acute Care

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CM	S-2	552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S	8-8	
			Component	CCN: 15-8512	From 10/01/2022 To 09/30/2023			
					RHC I	Cos:		2 4111
			<b>'</b>			,		
					1.	00		
1. 00	Clinic Address and Identification Street				540 HOSPITAL D	NDI VE	_	1. 00
1.00	Sti ee t		Ci	ty	State	ZIP Code		1.00
				00	2. 00	3. 00		
2.00	City, State, ZIP Code, County		WI NI MAC		IN	46996-		2. 00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "II" for	urban		1.00	0	3. 00
0.00	THOUSE THE BROOD FAMOUR ON THE BOOK BROOK STATE	<u> </u>			nt Award	Date		0.00
					1. 00	2. 00		
4 00	Source of Federal Funds	A . 1 >				T		4 00
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A					•		4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34							6. 00
7. 00	Appal achi an Regi onal Commissi on	-(-),,						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	ospi tal -based R	RHC or FQHC? E	nter "Y" for		2.00	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.)							
	illour 3. )	Sund	day	l N	londay	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3. 00	4. 00	5. 00		
11 00	Facility hours of operations (1) CLINIC			08: 00	17: 00	08: 00		11.00
11.00	1 100.00						11.00	
					1. 00	2. 00		
12.00	Have you received an approval for an excepti				N			12.00
13. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes,	enter in colu	mn 2 the	N		0	13. 00
	Indiliber's berow.			Prov	ider name	CCN		
					1. 00	2. 00		
14. 00	RHC/FQHC name, CCN							14.00
		Y/N 1. 00	2. 00	3. 00	XIX	Total Visit	S	
15 00	Have you provided all or substantially all	1.00	2.00	3.00	4. 00	5. 00		15. 00
13.00	GME cost? Enter "Y" for yes or "N" for no in							13.00
	column 1. If yes, enter in columns 2, 3 and							
	4 the number of program visits performed by							
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the							
	number of total visits for this provider.							
	(see instructions)							
				unty				
2. 00	City, State, ZIP Code, County	Ir	4. PULASKI	00			-	2.00
2.00	orty, State, Zir Code, County	Tuesday		esday	Thur	sday	$\dashv$	∠. 00
		to	from	to	from	to		
		6. 00	7. 00	8. 00	9. 00	10.00		
11 00	Facility hours of operations (1)	17. 20	20.00	10.00	00.00	110.00		11 00
11.00	CLINIC	17: 30	08: 00	19: 00	08: 00	19: 00	- 1	11. 00

Health Financial Systems	PULASKI MEMOR	RIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 15-1305	Peri od:	Worksheet S-8	
					From 10/01/2022		
			Component	CCN: 15-8512	To 09/30/2023		
			•			2/27/2024 9: 3	2 am
					RHC I	Cost	
	Fri	i day		Sa	turday		
	from		to	from	to		
	11. 00		12. 00	13. 00	14. 00		
Facility hours of operations (1)							
11. 00 CLINIC	08: 00	16:	30	08: 00	12: 00		11.00

Heal th	n Financial Systems	PULASKI MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10	
H0SPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	8	
			Component	CCN: 15-8527	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/27/2024 9:3		
					RHC II	Cost	02 diii	
			<u>.</u>					
					1.	00		
1 00	Clinic Address and Identification Street				NORTH LANE STR	CCT	1 00	
1. 00	Street		Ci	ty	State	ZIP Code	1.00	
				00	2.00	3. 00		
2. 00	City, State, ZIP Code, County	N	NORTH JUDSON		IN	46366-1226	2.00	
0.00	HOODITAL DACED FOLIO ONLY Designation Full	II DII C	1			1.00	2 2 22	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	or "U" for		nt Award	C Date	3.00	
			2. 00					
	Source of Federal Funds			1	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 8. 00	Appalachian Regional Commission Look-Alikes						7. 00 8. 00	
9. 00	OTHER (SPECIFY)						9.00	
7. 00	(or correspond						7.00	
					1. 00	2. 00		
10.00	<b>3</b> 1					C	10.00	
	yes or "N" for no in column 1. If yes, indic							
	2. (Enter in subscripts of line 11 the type of hours.)	of other operati	on(s) and the	operating				
	Tiour S. )	Suno	lav	Ι	Monday	Tuesday		
		from	to	from	to	from		
		1. 00	2.00	3.00	4.00	5. 00		
	Facility hours of operations (1)	,					11.00	
11. 00	CLINIC		08: 00 17: 00 08: 00					
					1. 00	2. 00	+	
12. 00	Have you received an approval for an excepti	on to the produ	ctivity stand	ard?	1.00 N	2.00	12.00	
13. 00						C	13.00	
	30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the				
	number of providers included in this report.	List the names	of all provi	ders and				
	numbers below.			Drov	i dor nome	CCN		
				PIOV	ider name 1.00	2. 00	+	
14. 00	RHC/FQHC name, CCN					2.00	14.00	
		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	F	PULASKI				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)	17: 00	08: 00	17: 00	08: 00	17: 00	11.00	

Health Financial Systems	PULASKI I	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 15-1305	Peri od:	Worksheet S-8	
			Component	CCN: 15-8527	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
						2/27/2024 9: 32 am	
				_	RHC II	Cost	
	Fri day		y	Sa	Saturday		
	from	1	to	from	to		
	11. 00	0	12. 00	13. 00	14. 00		
Facility hours of operations (1)							
11. 00 CLINIC	08: 00	17:	: 00				11. 00

Health Financial Systems	PULASKI MEMORIA			In Lie	eu of Form CMS	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			CCN: 15-1305	Peri od: From 10/01/2022		
		Component	CCN: 15-8528	To 09/30/2023	2/27/2024 9:	
				RHC III	Cost	
				1	. 00	
Clinic Address and Identification  .00 Street				112 E MONTGOME	FRY STREET	1.0
			ty	State	ZIP Code	
0.00 City State 7LD Code County		1. FRANCESVI LLE	00	2.00	3. 00 \47946-8087	2.0
2.00   City, State, ZIP Code, County	ĮF	-RANCESVILLE			147940-8087	2.0
.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "D" for rura	l or "II" for	urhan		1.00	0 3.0
.00   HOSFITAL-BASED TUNES ONLT. Designation - Effe	si k ioi iuia	0 0 101		nt Award	Date	0 3.0
				1.00	2. 00	
Source of Federal Funds .00 Community Health Center (Section 330(d), PHS	Λc+)		T		T	4.0
5.00 Migrant Health Center (Section 339(d), PHS Ac						5.0
0.00 Health Services for the Homeless (Section 340						6.0
7.00 Appalachian Regional Commission						7.0
1.00 Look-Alikes 1.00 OTHER (SPECIFY)						8. C
(5.25.17)						
0.00   D		110 - F01100 F	11.70	1.00	2. 00	0 10 0
0.00 Does this facility operate as other than a house or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operatio	ns in column	N		0 10.0
	Sund	lay		londay	Tuesday	
	from	to	from	to	from	
Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 CLINIC			08: 00	17: 00	09: 00	11.0
				1.00 2.00		
2.00 Have you received an approval for an exception	on to the produ	ctivity stand	lard?	Y	2.00	12.0
3.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below.	umn 1. If yes,	enter in colu	mn 2 the	N		0 13.0
				der name	CCN	
4.00 RHC/FQHC name, CCN				1. 00	2. 00	14.0
4. 00   KHC/ FUNC Hallie, CCN	Y/N	V	XVIII	XIX	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 column 1. If yes, enter in columns 2, 3 and						15.0
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)						
			unty			
			00			2.0
2.00 City State 7LP Code County	lr.			1		Z. U
2.00 City, State, ZIP Code, County		PULASKI Wedn	esday	Thu	rsday	
2.00 City, State, ZIP Code, County	Tuesday to		esday to	Thu from	rsday to	
2.00 City, State, ZIP Code, County  Facility hours of operations (1)	Tuesday	Wedn	1 -			

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 15-1305	Peri od:	Worksheet S-8	}
			Component	CCN: 15-8528	From 10/01/2022 To 09/30/2023		pared:
					RHC III	2/2//2024 9: 3 Cost	2 alli
	Fri day		y		turday		
	fro	m	to	from	to		
	11. (	00	12. 00	13.00	14. 00		
Facility hours of operations (1)							
11. 00 CLINIC							11. 00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	8
		Component	CCN: 15-8554	From 10/01/2022 To 09/30/2023		
				RHC I V	Cost	
				1.	00	
Clinic Address and Identification						
1.00   Street		Ci	ty	2 S. PEARL STR State	ZIP Code	1.00
			00	2. 00	3. 00	
2.00 City, State, ZIP Code, County	I	KNOX			46534	2.00
2 00 HOSDITAL BASED FOHCE ONLY. Designation Ent	or "D" for rure	d or "II" for	urban		1.00	3.00
3.00   HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er R TOFTUFA	11 01 0 101		nt Award	Date	3.00
	1.00					
Source of Federal Funds						
4.00 Community Health Center (Section 330(d), PHS						4.00
5.00 Migrant Health Center (Section 329(d), PHS A 6.00 Health Services for the Homeless (Section 34						5.00
7.00 Appal achi an Regional Commission	U(u), FIIS ACT)					7.00
8. 00 Look-Alikes						8. 00
9. 00 OTHER (SPECIFY)						9.00
				1.00	2.00	
10.00 Does this facility operate as other than a h	nsnital_hased F	RHC or FOHC2 F	nter "V" for	1. 00 N	2. 00	10.00
yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of c	other operatio	ns in column			10.00
nour s. y	Sunday Monday				Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3.00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	19: 00	08: 00	11.00
11. 00 CEIMIO			100.00	17.00	00.00	11.00
				1. 00	2. 00	
12.00 Have you received an approval for an excepti				Y		12.00
13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the	N		13.00
number of providers included in this report. numbers below.	LIST THE Hallies	s or arr provi	ueis anu			
			Prov	ider name	CCN	
				1. 00	2. 00	
14.00 RHC/FQHC name, CCN	V /NI	V	V/// 1 1	VIV	Total Waits	14.00
	Y/N 1. 00	2. 00	3. 00	4. 00	Total Visits 5.00	
15.00 Have you provided all or substantially all	1.00	2.00	3.00	4.00	3.00	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)						
			unty			
2.00 City, State, ZIP Code, County		4.	00			2.00
2. 33 State, 211 Code, County	Tuesday	Wedn	esday	Thur	rsday	2.00
	to	from	to	from	to	
T	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)	10:00	00.00	10.00	00.00	10, 00	11 00
11. 00   CLINIC	19: 00	08: 00	19: 00	08: 00	19: 00	11.00

Health Financial Systems	PULASKI MEMOR	I AL HOSP	I TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Prov	ider CC		Peri od:	Worksheet S-8	
					From 10/01/2022		
		Comp	onent C	CCN: 15-8554	To 09/30/2023		
		· ·				2/27/2024 9: 3	2 am
					RHC IV	Cost	
	Fri	day		Sat	urday		
	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

Heal th Financial Systems
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA Uncompensated and Indigent Care Cost-to-Charge Ratio  1.00 Cost to charge ratio (see instructions) 0.456369  Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid YY 3.00  4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? N 4.00  5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? N 4.00  6.00 Medicaid charges 12,041,051 6.00  7.00 Medicaid cost (line 1 times line 6) 5,495,162 7.00  8.00 Difference between net revenue and costs for Medicaid program (see instructions) 4,447,594  Children's Heal th Insurance Program (CHIP) (see instructions for each line)  9.00 Net revenue from stand-alone CHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) 0 11.00  12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) 0 11.00  13.00 Other state or local government indigent care program (Not included on lines 2, 5 or 9) 0 13.00  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14) 0 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 15.00  Grants, donations and total unrel mbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions) 0 16.00  Grants, donations and total unrel mbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 16.00  18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA Uncompensated and Indigent Care Cost-to-Charge Ratio  1.00 Cost to charge ratio (see instructions) 0.456369  Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid YY 3.00  4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? N 4.00  5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? N 4.00  6.00 Medicaid charges 12,041,051 6.00  7.00 Medicaid cost (line 1 times line 6) 5,495,162 7.00  8.00 Difference between net revenue and costs for Medicaid program (see instructions) 4,447,594  Children's Heal th Insurance Program (CHIP) (see instructions for each line)  9.00 Net revenue from stand-alone CHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) 0 11.00  12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) 0 11.00  13.00 Other state or local government indigent care program (Not included on lines 2, 5 or 9) 0 13.00  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14) 0 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 15.00  Grants, donations and total unrel mbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions) 0 16.00  Grants, donations and total unrel mbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 16.00  18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00
Cost to charge ratio (see instructions)  Medicaid (see instructions for each line)  Not revenue from Medicaid  100 Medicaid (see instructions for each line)  101 you receive DSH or supplemental payments from Medicaid?  102 Variety of the supplemental payments from Medicaid?  103 00 Uf line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  104 00 Uf line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  105 Variety of the supplemental payments from Medicaid?  106 Variety of the supplemental payments from Medicaid?  107 Variety of the supplemental payments from Medicaid?  108 Variety of the supplemental payments from Medicaid?  109 Variety of the supplemental payments from Medicaid?  100 Variety of the supplemental payments from Medicaid?  101 Variety of the supplemental payments from Medicaid?  102 Variety of the supplemental payments from Medicaid?  103 Variety of the supplemental payments from Medicaid?  100 Variety of the supplemental payments from Medicaid?  100 Variety of the supplemental payments from Medicaid?  100 Variety of the supplemental pay
Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid  811, 738 2.00  4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  N 4.00  5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid?  N 4.00  6.00 Medicaid charges  12, 041, 051 6.00  8.00 Difference between net revenue and costs for Medicaid program (see instructions)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions)  10.00 Stand-alone CHIP cost (line 1 times line 10)  11.00 Stand-alone CHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)  12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 10, 00 lifference between net revenue and costs for stand or state or local indigent care program (Not included in lines 6 or 10, 10, 00 lifference between net revenue and costs for stand or local indigent care program (Not included in lines 6 or 10, 10, 00 lifference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10, 10, 00 lifference between net revenue and costs for state or local indigent care program (see instructions)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  17.00 Private grants, donations, or endowment income restricted to funding charity care  17.00 Private grants, donations, or ransfers for support of hospital operations  18.00 Government grants, appropriations or transfers for support of hospital operations
Net revenue from Medicaid   S11,738   2.00
3.00   Did you receive DSH or supplemental payments from Medicaid?   Y   3.00   4.00   If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?   N   4.00   6.00   If line 4 is no, then enter DSH and/or supplemental payments from Medicaid   235,830   5.00   Medicaid charges   12,041,051   6.00   7.00   Medicaid cost (line 1 times line 6)   5,495,162   7.00   Medicaid cost (line 1 times line 6)   5,495,162   7.00   Difference between net revenue and costs for Medicaid program (see instructions)   4,447,594   8.00   Children's Health Insurance Program (CHIP) (see instructions for each line)   9.00   Net revenue from stand-alone CHIP (see instructions)   0   10.00
4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid  235,830 5.00  Medicaid charges  12,041,051 6.00  Medicaid cost (line 1 times line 6)  5.495,162 7.00  Medicaid cost (line 1 times line 6)  8.00 Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-al one CHIP  Stand-al one CHIP charges  12,041,051 6.00  8.00 Difference between net revenue and costs for Medicaid program (see instructions)  11.00 Difference between net revenue and costs for stand-al one CHIP (see instructions)  Other state or local government indigent care program (Not included on lines 2, 5 or 9)  13.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  14.00 Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)  15.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  16.00 Crants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions)  Other state or local indigent care program (see instructions)  Other state or local indigent care program (see instructions)  Other state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 11.00)  Other state or local indigent care program (Not included in lines 6 or 11.00)  Other state or local indigent care program (Not included in lines 6 or 11.00)  Other state or local indigent care program (Not included in lines
5.00   If line 4 is no, then enter DSH and/or supplemental payments from Medicaid   235, 830   5.00   6.00   Medicaid charges   12,041,051   6.00   7.00   Medicaid cost (line 1 times line 6)   5,495, 162   7.00   Difference between net revenue and costs for Medicaid program (see instructions)   4,447,594   8.00   Children's Health Insurance Program (CHIP) (see instructions for each line)   9.00   Net revenue from stand-alone CHIP   0   9.00   10.00   Stand-alone CHIP cost (line 1 times line 10)   11.00   12.00   Difference between net revenue and costs for stand-alone CHIP (see instructions)   0   11.00   1
7.00 Medicaid cost (line 1 times line 6) 8.00 Difference between net revenue and costs for Medicaid program (see instructions) Children's Health Insurance Program (CHIP) (see instructions for each line)  9.00 Net revenue from stand-alone CHIP Stand-al one CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) 0 ther state or local government indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 15.00 Times covered under state or local indigent care program (see instructions) 0 16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 16.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00
8.00 Difference between net revenue and costs for Medicaid program (see instructions)  9.00 Net revenue from stand-al one CHIP  9.00 Stand-al one CHIP charges  11.00 Difference between net revenue and costs for stand-al one CHIP (see instructions)  12.00 Difference between net revenue and costs for stand-al one CHIP (see instructions)  13.00 Net revenue from state or local indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  15.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  17.00 Private grants, donations, or endowment income restricted to funding charity care  17.00 Government grants, appropriations or transfers for support of hospital operations  0 16.00 Difference between net revenue and costs for support of hospital operations  0 17.00 Difference between net revenue and costs for support of hospital operations
Children's Health Insurance Program (CHIP) (see instructions for each line)  9.00 Net revenue from stand-al one CHIP Stand-al one CHIP charges 11.00 Stand-al one CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-al one CHIP (see instructions) 0 ther state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 15.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Government grants, appropriations or transfers for support of hospital operations
9.00 Net revenue from stand-al one CHIP 10.00 Stand-al one CHIP charges 11.00 Stand-al one CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-al one CHIP (see instructions) 12.00 Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 16.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 17.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00
10.00 Stand-alone CHIP charges 11.00 Stand-alone CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) 0 12.00 Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 15.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Government grants, appropriations or transfers for support of hospital operations
11.00 Stand-alone CHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 9)  Other state or local indigent care program (Not included in lines 6 or 9)  Other state or local indigent care program (Not included in lines 6 or 9)  Other state or local indigent care
12.00  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  13.00  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  15.00  Difference between net revenue and costs for state or local indigent care program (see instructions)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (Not included in lines 6 or 10)  Other
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  17.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  18.00 Government grants, appropriations or transfers for support of hospital operations  0 13.00  16.00 17.00
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  0 14.00 15.00 16.00 17.00 18.00
15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00  16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 16.00  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00  18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00
15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)  17.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  18.00 Government grants, appropriations or transfers for support of hospital operations  0 15.00 16.00 17.00 18.00
16.00 Difference between net revenue and costs for state or local indigent care program (see instructions) 0 16.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  0 17.00 18.00
instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  18.00 Government grants, appropriations or transfers for support of hospital operations  0 17.00 18.00
18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00
19.00   Total uniterimbulsed cost for Medicard, Chir and State and rocal fluigent care programs (sum of fines) 4,447,3941 19.00
8, 12 and 16)
Uninsured Insured Total (col. 1
patients patients + col. 2)
1.00 2.00 3.00
Uncompensated care cost (see instructions for each line) 20.00 Charity care charges and uninsured discounts (see instructions) 10,907 186,804 197,711 20.00
21. 00 Cost of patients approved for charity care and uninsured discounts (see 4, 978 186, 804 191, 782 21. 00
instructions)
22.00 Payments received from patients for amounts previously written off as 0 0 0 22.00
charity care
23. 00   Cost of charity care (see instructions)   4, 978   186, 804   191, 782   23. 00
1.00
24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit N 24.00
imposed on patients covered by Medicaid or other indigent care program?
25.00   If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 0 25.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 25.01 Charges for insured patients' liability (see instructions) 0 25.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  25.01 Charges for insured patients' liability (see instructions)  0 25.00  26.00 Bad debt amount (see instructions)  0 25.01  843,549 26.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  25.01 Charges for insured patients' liability (see instructions)  0 25.00  26.00 Bad debt amount (see instructions)  0 25.01  843,549 26.00
25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  25. 01 Charges for insured patients' liability (see instructions)  26. 00 Bad debt amount (see instructions)  27. 00 Medicare reimbursable bad debts (see instructions)  28. 00 25. 00  29. 00 25. 00  27. 00 Medicare reimbursable bad debts (see instructions)
25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  25. 01 Charges for insured patients' liability (see instructions)  26. 00 Bad debt amount (see instructions)  27. 00 Medicare reimbursable bad debts (see instructions)  27. 01 Medicare allowable bad debts (see instructions)  28. 00 Non-Medicare bad debt amount (see instructions)  29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)  340, 752 29. 00
25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  25. 01 Charges for insured patients' liability (see instructions)  26. 00 Bad debt amount (see instructions)  27. 00 Medicare reimbursable bad debts (see instructions)  27. 01 Medicare allowable bad debts (see instructions)  28. 00 Non-Medicare bad debt amount (see instructions)  29. 00 Variable indigent care program's length of stay length of stay limit  29. 01 843, 549 26. 00  270, 212 27. 01  28. 00 Non-Medicare bad debt amount (see instructions)  415, 712 27. 01  427, 837 28. 00

HOSPI	FAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCI	N: 15-1305	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-1 Parts I & II Date/Time Pre 2/27/2024 9:3	pared:		
					1. 00			
	PART II - HOSPITAL DATA					1		
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
. 00	Cost to charge ratio (see instructions)					1.00		
	Medicaid (see instructions for each line)							
2. 00	Net revenue from Medicaid					2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?			: -10		3.00		
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments 1 line 4 is no, then enter DSH and/or supplemental payments 1	1 2		car d?		4.00		
5. 00								
7. 00								
3. 00	0 Difference between net revenue and costs for Medicaid program (see instructions)							
. 00	Children's Health Insurance Program (CHIP) (see instructions for each line)							
9. 00	Net revenue from stand-alone CHIP	or caen irin	<i>-</i> /			9.00		
0. 00						10.00		
1. 00						11.0		
2. 00	Difference between net revenue and costs for stand-alone CHIP	(see instru	ctions)			12.0		
	Other state or local government indigent care program (see ins	structions fo	or each line	e)		1		
13.00								
14.00								
	10)							
	5.00 State or local indigent care program cost (line 1 times line 14)							
16.00	OD Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	instructions for each line)	and State	e/rocar rndi	gent care progra	ims (see			
17 00		fundi ng chari	ty care			17.00		
18. 00	.00 Private grants, donations, or endowment income restricted to funding charity care .00 Government grants, appropriations or transfers for support of hospital operations							
19. 00	9 11 1			ns (sum of lines		18. 00 19. 00		
	8, 12 and 16)	3	, 3	`				
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col. 2)			
			1. 00	2. 00	3. 00			
	Uncompensated care cost (see instructions for each line)	, ,						
0.00	,					20.0		
1. 00	1	ounts (see				21.0		
2 00	instructions)	off oo				22.00		
∠. ∪∪	Payments received from patients for amounts previously written	i oii as				22. 0		
3 00	charity care Cost of charity care (see instructions)					23.00		
.5.00	10031 of chartry care (see Histructions)					23.00		
					1. 00			
4. 00	Does the amount on line 20 col. 2, include charges for patient	t days bevon	d a Length	of stay limit		24.00		
	imposed on patients covered by Medicaid or other indigent care		3	,				
5. 00	If line 24 is yes, enter the charges for patient days beyond to	the indigent	care progra	am's length of		25.00		
	stay limit	-		~		1		

26. 00 27. 00

27.01

28. 00 29. 00

30.00

31.00

25.01 Charges for insured patients' liability (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

26.00 Bad debt amount (see instructions)
27.00 Medicare reimbursable bad debts (see instructions)

27.01 Medicare allowable bad debts (see instructions)

Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Period: From 10/01/2022	Worksheet A	
					To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
	Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
				+ col . 2)	i ons (See A-6)	Trial Balance (col. 3 +-	
					7, 0)	col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		2 0/0 005	2 0/0 00	- (1.504	2 120 200	1 00
1. 00 4. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT   OO400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 068, 895 5, 701, 723			2, 130, 399 5, 701, 723	1.00 4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	2, 910, 093	4, 827, 296				5.00
7. 00	00700 OPERATION OF PLANT	384, 638	632, 547	1, 017, 18			
8.00	00800 LAUNDRY & LINEN SERVICE	8, 949	69, 536			78, 485	
9. 00	00900 HOUSEKEEPI NG	225, 382	145, 801	371, 183		371, 183	
10.00	01000 DI ETARY	225, 361	196, 863			421, 859	
13. 00 14. 00	01300   NURSI NG   ADMI NI STRATI ON   01400   CENTRAL   SERVI CES & SUPPLY	414, 344 28, 870	59, 987 41, 397	474, 33° 70, 26°		474, 331 70, 267	
15. 00	01500 PHARMACY	20, 0, 0	0			0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	324, 369	45, 550	369, 919	-31, 090	338, 829	
17. 00	01700 SOCIAL SERVICE	53, 566	18	53, 584	4 0	53, 584	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 007 550	452 777	2 051 220	00.407	2 141 017	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 897, 552 0	153, 777 0	2, 051, 329	90, 487	2, 141, 816 0	30.00
43. 00	04300 NURSERY	0	0				
.0.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		10.00
50.00	O5000 OPERATING ROOM	651, 662	138, 321	789, 983	892, 666	1, 682, 649	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1 01/ 703	558, 790	558, 790		557, 182	
54. 00 60. 00	06000 LABORATORY	1, 016, 783 782, 317	610, 534 859, 748	1, 627, 31 1, 642, 06		1, 327, 920 1, 599, 102	
60. 01	06001 BLOOD LABORATORY	702, 317	037, 740	1,042,00	0 -42, 703	1, 377, 102	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	51, 349	51, 349	9 0	51, 349	
65.00	06500 RESPI RATORY THERAPY	373, 077	38, 373			411, 450	
66.00	06600 PHYSI CAL THERAPY	974, 835	25, 659			1, 000, 212	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	185, 476	1, 633 193			187, 109 193	1
69.00	06900 ELECTROCARDI OLOGY	0	14, 341	193 14, 34		14, 341	1
69. 01	06901 CARDI AC REHABI LI TATI ON	72, 864	3, 816			76, 115	
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	. (	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	749, 715	749, 71			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0 544 00	79, 676		
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	84, 262 148, 223	2, 427, 035 48, 399			2, 505, 156 196, 481	
70.00	OUTPATIENT SERVICE COST CENTERS	140, 223	40, 377	190, 022	- 141	170, 401	70.00
88.00	08800 RURAL HEALTH CLINIC	5, 926, 165	470, 490	6, 396, 65	-1, 551, 061	4, 845, 594	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	571, 461	99, 739			773, 522	
88. 02	08802 RURAL HEALTH CLINIC III	134, 932	32, 052			235, 349	
88. 03 90. 00	08803 RURAL HEALTH CLINIC IV 09000 CLINIC	531, 156 66, 235	96, 176 197, 276	627, 332 263, 51			
	09001 WOUND CARE	129, 683	233, 033				
	09100 EMERGENCY	1, 252, 793	1, 502, 889				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				-1		
101.00	10100 HOME HEALTH AGENCY	0	0	(	0	0	101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0	0	(	0 0	0	116. 00
118.00		19, 375, 048	22, 102, 951				
	NONREI MBURSABLE COST CENTERS	, , , , , , , , ,	, , ,				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19001 HOMECARE	0	0		0		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES 19201 KNOX RHC	218, 079	209, 062	427, 14	0 0	427, 141	192. 00 192. 01
	19201 KNOX RHC 19202 RETALL PHARMACY	O O	21, 369	21, 36			192.01
	19203 CULVER	151, 193	117, 581	268, 774		268, 774	
194.00	07950 MARKETI NG	111, 237	165, 379			38, 210	194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	19, 855, 557	22, 616, 342	42, 471, 89	9 0	42, 471, 899	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-1305 Pe

Peri od: Worksheet A From 10/01/2022 To 09/30/2023 Date/Time Prepared:

2/27/2024 9:32 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocati on 6. 00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT -13, 241 2, 117, 158 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5, 701, 723 4.00 00500 ADMINISTRATIVE & GENERAL 6, 099, 770 5 00 -1.740.239 5 00 7.00 00700 OPERATION OF PLANT -278 1, 812, 677 7.00 00800 LAUNDRY & LINEN SERVICE 78, 485 8.00 8.00 9.00 00900 HOUSEKEEPI NG 0 371, 183 9.00 01000 DI ETARY 10.00 -58.559363, 300 10 00 13.00 01300 NURSING ADMINISTRATION 474, 331 13.00 14 00 01400 CENTRAL SERVICES & SUPPLY -15, 660 54,607 14.00 01500 PHARMACY 15.00 15.00 C 01600 MEDICAL RECORDS & LIBRARY 334, 252 16.00 -4.577 16.00 17.00 01700 SOCIAL SERVICE 53, 584 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS -481, 899 1, 659, 917 31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM -933, 477 749, 172 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 05300 ANESTHESI OLOGY 53.00 -550, 000 7, 182 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 1, 327, 920 54.00 60.00 06000 LABORATORY 0 1, 599, 102 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0 51, 349 63.00 63.00 06500 RESPIRATORY THERAPY 0 65.00 411.450 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,000,212 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 187, 109 67.00 68.00 06800 SPEECH PATHOLOGY 0 193 68.00 06900 ELECTROCARDI OLOGY 8, 907 69.00 -5, 434 69.00 69. 01 06901 CARDIAC REHABILITATION 0 76, 115 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 670,039 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 79,676 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 505, 156 73.00 03020 ONCOLOGY 76.00 -42, 877 153, 604 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 4, 845, 594 08800 RURAL HEALTH CLINIC 0 88.00 08801 RURAL HEALTH CLINIC II 0 773, 522 88.01 88 02 08802 RURAL HEALTH CLINIC III 235, 349 88.02 0 08803 RURAL HEALTH CLINIC IV 88.03 -13, 092 662, 929 88.03 90.00 09000 CLI NI C 263, 511 90.00 90.01 09001 WOUND CARE -96, 933 277, 137 90.01 09100 EMERGENCY 91 00 2, 753, 924 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 SUBTOTALS (SUM OF LINES 1 through 117) -3, 956, 266 37, 760, 139 118.00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN l190. 00 0 190. 01 19001 HOMECARE 190.01 192.00 19200 PHYSICIANS' PRIVATE OFFICES -13, 092 414, 049 192.00 192. 01 19201 KNOX RHC 192.01 0 192. 02 19202 RETAIL PHARMACY 0 21, 369 192.02 268, 774 192. 03 19203 CULVER 0 192.03 194. 00 07950 MARKETI NG 38, 210 194.00 200.00 TOTAL (SUM OF LINES 118 through 199) -3.969,358 38, 502, 541 200.00

					Date/Time Prepared:
		Increases			 2/27/2024 9: 32 am
	Cost Center	Li ne #	Salary	Other	
	2.00	3.00	4. 00	5. 00	
	A - PROPERTY INSURANCE RECLAS	S			
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	61, 504	1.00
	FIXT				
				61, 504	
	B - MARKETING RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5. 00	95, 871	142, 535	1.00
	0		95, 871	142, 535	
	C - IMPLANTABLE DEVICE RECLAS	S			
1.00	IMPL. DEV. CHARGED TO	72. 00	0	79, 676	1.00
	PATI ENTS				
	0		0	79, 676	
	D - PHYSICIAN SALARIES RECLAS				
1. 00	ADULTS & PEDIATRICS	30. 00	95, 028	0	1.00
2.00	OPERATING ROOM	50. 00	927, 909	0	2. 00
3. 00	RURAL HEALTH CLINIC II	88. 01	114, 639	0	3.00
4.00	RURAL HEALTH CLINIC III	88. 02	60, 732	0	4. 00
5. 00	RURAL HEALTH CLINIC IV	88. 03	27, 648	0	5. 00
6. 00	WOUND CARE	<u> </u>	11, 354	0	6. 00
	O FATHERIT ASSOCIATION PERILADO		1, 237, 310	0	
4 00	E - PATIENT ACCOUNTS RECLASS		4/7 700		1.00
1. 00	ADMI NI STRATI VE & GENERAL		167, 782	0	1.00
	U DUC DEDT 175 DECLACE		167, 782	U	
1. 00	F - RHC DEPT 175 RECLASS RURAL HEALTH CLINIC II	88. 01	ol	22, 413	1.00
2. 00	RURAL HEALTH CLINIC III	88. 02	ol Ol	7, 633	2.00
3. 00	RURAL HEALTH CLINIC IV	88. 03	o	23, 032	3.00
3.00	O CETTIVE TV				3.00
	H - MAINTENANCE RECLASS		<u> </u>	33, 070	
1. 00	OPERATION OF PLANT	7. 00	O	795, 770	1.00
2. 00	OF ERVITOR OF TEAM	0.00	o	0	2.00
3. 00		0.00	Ö	Ö	3.00
4. 00		0.00	o	Ö	4.00
5. 00		0. 00	Ö	0	5. 00
6. 00		0. 00	o	Ö	6.00
7. 00		0. 00	0	0	7. 00
8. 00		0. 00	o	Ö	8.00
9. 00		0.00	0	0	9.00
10.00		0.00	О	0	10.00
11. 00		0.00	o	0	11.00
12.00		0. 00	O	0	12.00
13.00		0.00	0	0	13.00
14.00		0. 00	o	0	14.00
15. 00		000	0	0	15. 00
	TOTALS		0	795, 770	
500.00	Grand Total: Increases		1, 500, 963	1, 132, 563	500.00

Peri od: Worksheet A-6
From 10/01/2022 Provi der CCN: 15-1305

						To 09/30/2023	Date/Time Prepared: 2/27/2024 9:32 am
		Decreases					272772021 7. 02 4
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	·.	
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - PROPERTY INSURANCE RECLASS						
1.00	ADMI NI STRATI VE & GENERAL		0	6 <u>1, 5</u> 04	1	2	1.00
	0		0	61, 504			
	B - MARKETING RECLASS						
1.00	MARKETI NG	19400	9 <u>5, 8</u> 71	14 <u>2, 5</u> 35		<u>o</u>	1.00
	0		95, 871	142, 535	5		
	C - IMPLANTABLE DEVICE RECLASS					. T	
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	79, 676		0	1.00
	PATI ENTS	+				_	
	0		0	79, 676			
4 00	D - PHYSICIAN SALARIES RECLASS	00.00	4 000 500				1.00
1.00	RURAL HEALTH CLINIC	88. 00	1, 202, 580	0	1	0	1.00
2.00	RURAL HEALTH CLINIC II	88. 01	34, 730	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0	1	0	4.00
5.00		0. 00 0. 00	U	0			5.00
6. 00		0.00				의 -	6. 00
	E - PATIENT ACCOUNTS RECLASS		1, 237, 310	U	)		
1. 00	RURAL HEALTH CLINIC	88. 00	167, 782		<b>.</b>	ol	1, 00
1.00	O CONTRACTOR CETATOR		167, 782		<del></del>	9	1.00
	F - RHC DEPT 175 RECLASS		107, 702		<u>' </u>		
1. 00	RURAL HEALTH CLINIC	88. 00	٥	53, 078		ol	1.00
2. 00	ROIVE HEALTH GETTI G	0. 00	0	33, 070		o o	2.00
3. 00		0. 00	o	0		o o	3.00
0.00			<del> </del>	53, 078		9	0.00
	H - MAINTENANCE RECLASS		<u> </u>	00,070	1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	242, 064		ol	1.00
2. 00	DI ETARY	10. 00	Ö	365		ol	2. 00
3. 00	MEDICAL RECORDS & LIBRARY	16. 00	o	31, 090		ol	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	4, 541		ol	4.00
5.00	OPERATING ROOM	50.00	O	35, 243	3	o	5. 00
6.00	ANESTHESI OLOGY	53.00	0	1, 608	3	o	6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	O	299, 397	,	o	7. 00
8.00	LABORATORY	60.00	O	42, 963	3	o	8.00
9.00	PHYSI CAL THERAPY	66. 00	0	282	2	0	9. 00
10.00	CARDIAC REHABILITATION	69. 01	0	565	5	0	10.00
11. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	6, 141		0	11.00
12.00	ONCOLOGY	76. 00	0	141		0	12.00
13.00	RURAL HEALTH CLINIC	88. 00	0	127, 621		0	13.00
14.00	RURAL HEALTH CLINIC IV	88. 03	0	1, 991		0	14.00
15.00	EMERGENCY	91.00	0	<u>1, 7</u> 58		<u>이</u>	15.00
	TOTALS		0	795, 770			
500.00	Grand Total: Decreases		1, 500, 963	1, 132, 563	<b> </b>		500.00

| Period: | Worksheet A-7 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared:

				To	09/30/2023	Date/Time Pre	
				Acqui si ti ons		2/27/2024 9: 3	2 am
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances	rui Cliases	Donation	iotai	Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	3.00	4.00	5.00	
1. 00	Land	195, 525	41, 382	0	41, 382	0	1.00
2. 00	Land Improvements	432, 594	41, 302	0	41, 30 <u>2</u>	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 Equi pment	7, 548, 063	184, 762	0	184, 762	0	5.00
6. 00	Movable Equipment	15, 552, 260	2, 061, 116	0	2, 061, 116		6.00
7. 00	HIT designated Assets	13, 332, 200	2,001,110	0	2,001,110	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	37, 168, 535	2, 287, 260	0	2, 287, 260	0	8.00
9. 00	Reconciling Items	07, 100, 000	2, 207, 200	0	2, 207, 200	0	9.00
10.00	Total (line 8 minus line 9)	37, 168, 535	2, 287, 260	0	2, 287, 260		10.00
	Total (Title & milias Title 7)	Endi ng	Fully	5	2,20,,200		10100
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	236, 907	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 Equi pment	7, 732, 825	0				5. 00
6.00	Movable Equipment	17, 613, 376	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	39, 455, 795	0				8.00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	39, 455, 795	O				10.00

Health Financial Systems	PULASKI MEMORI	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 10/01/2022 To 09/30/2023	Worksheet A-7 Part II Date/Time Pre 2/27/2024 9:3	pared:
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10. 00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	- <del>1</del>		
1.00 NEW CAP REL COSTS-BLDG & FLXT	1, 502, 728	0	566, 16	7 0	0	1.00
3.00 Total (sum of lines 1-2)	1, 502, 728		566, 16	7 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	2, 068, 895		·		1.00
3.00 Total (sum of lines 1-2)	0	2, 068, 895	i			3. 00

Heal th	Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 10/01/2022 To 09/30/2023		nared:
						2/27/2024 9: 32	
		COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Coot Conton Decemintion	Cross Assets	Conitalized	Gross Assets	Doti o Cooo	Lnouronoo	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	for Ratio	Ratio (see instructions)	Insurance	
			Leases	(col. 1 -	Tristructions)		
				col . 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FLXT	39, 455, 795	l .	39, 455, 795			1.00
3. 00	Total (sum of lines 1-2)	39, 455, 795		39, 455, 795			3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Conton Decemintion	Toyoo	Other	Total (our of	Donnooiation	Lagge	
	Cost Center Description	Taxes	Capi tal -Rel at	Total (sum of cols. 5	Depreciation	Lease	
			ed Costs	through 7)			
		6, 00	7.00	8.00	9, 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		2.22			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(	1, 501, 995	0	1.00
3.00	Total (sum of lines 1-2)	0	0	(	1, 501, 995	0	3.00
			SL	JMMARY OF CAPI	TAL		
					1		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	553, 659	61, 504		0	2, 117, 158	1.00
3.00	Total (sum of lines 1-2)	553, 659		•	0	2, 117, 158	3.00

				To	09/30/2023	Date/Time Pre 2/27/2024 9:3	
				Expense Classification on			
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Investment income - NEW CAP		C	NEW CAP REL COSTS-BLDG &	1. 00	0	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL		C	*** Cost Center Deleted ***	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2)		,		0. 00	0	3.00
3.00	(chapter 2)			,	0.00		3.00
4. 00	Trade, quantity, and time		C		0. 00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of				0. 00	0	5.00
	expenses (chapter 8)		_				
6. 00	Rental of provider space by suppliers (chapter 8)		(		0. 00	0	6.00
7. 00	Tel ephone servi ces (pay		C		0. 00	0	7.00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		C		0. 00	0	8.00
	(chapter 21)		_		0.00		
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-1, 560, 620		0. 00	0	
10.00	adj ustment	N 0 2	1, 300, 020				10.00
11. 00			C		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	C			O	12.00
40.00	transactions (chapter 10)				0.00		10.00
13. 00 14. 00	1 -				0. 00 0. 00	0	
15. 00	Rental of quarters to employee		Č		0. 00	0	1
14 00	and others				0.00	0	14 00
16. 00	Sale of medical and surgical supplies to other than			,	0. 00	U	16.00
	patients		_				
17. 00	Sale of drugs to other than patients				0. 00	0	17.00
18.00	1. I		C		0. 00	0	18.00
10.00	abstracts		,		0.00	0	19.00
19. 00	Nursing and allied health education (tuition, fees,			,	0. 00	U	19.00
	books, etc.)		_		0.00		
	Vending machines Income from imposition of				0. 00 0. 00	0	
21.00	interest, finance or penalty				0.00	١	200
22. 00	charges (chapter 21) Interest expense on Medicare		(		0. 00		22.00
22.00	overpayments and borrowings to			,	0.00		22.00
00.00	repay Medicare overpayments			DECDI DATORY THERABY	<b>(5.00</b>		00.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3		RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66. 00		24. 00
	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
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2. 00	0	27.00
27.00	COSTS-MVBLE EQUIP				2.00		7 27.00
28. 00	1		(	*** Cost Center Deleted ***	19. 00		28.00
29. 00 30. 00		A-8-3		OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of				230		
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		(	ADULTS & PEDIATRICS	30. 00		30. 99
55. 77	instructions)			The second of th	30.00		55. 77
	·	·		'	·		

Heal th	n Financial Systems		PULASKI MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUS'	TMENTS TO EXPENSES				eri od:	Worksheet A-8	
					rom 10/01/2022		
					o 09/30/2023	Date/Time Pre 2/27/2024 9:3	
				Expense Classification on	Worksheet A	, _,, _,,	
				To/From Which the Amount is			
					Ĵ		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				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	_					
33. 00	INVEST INC/UNRESTRIC- INT EXP	В		NEW CAP REL COSTS-BLDG &	1. 00	11	33.00
00.04	OTHER CERVI OFC. OTHER REV	,		FIXT	F 00		00.04
	OTHER SERVICES -OTHER REV	В		ADMINISTRATIVE & GENERAL	5.00	0	
	CAFETERIA VENDING - OTHER REV	В		DI ETARY	10.00	0	33. 02
	REBATES & REFUNDS - OTHER REV	В		CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33. 04	MEDICAL RECORDS FEES -OTHER REV	В	-4, 5//	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 04
33. 08		_	270	OPERATION OF PLANT	7 00	0	22 00
33.08		A		ADMINISTRATIVE & GENERAL	7. 00	0	33. 08 33. 09
33. 09		A			5. 00	0	
33. 10	LOBBYING EXPENSE CRNA	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 10
	T	A		ANESTHESI OLOGY	53.00	0	33. 11
33. 12	-	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12 33. 13
33. 13	EHR DEPRECIATION ON 2012 PAYMENT	A		NEW CAP REL COSTS-BLDG & FLXT	1.00	9	33.13
33. 14	RENTAL INCOME - KNOX	В	-13, 092	RURAL HEALTH CLINIC IV	88. 03	0	33. 14
	RENTAL INCOME - PHYSICIAN	В	-13, 092	PHYSICIANS' PRIVATE OFFICES	192. 00	0	33. 15
EO 00	TOTAL (cum of lines 1 thru 40)	1	2 040 250		1		E0 00

-3, 969, 358

50.00

50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1305

Peri od: Worksheet A-8-2 From 10/01/2022 09/30/2023 Date/Time Prepared:

2/27/2024 9:32 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5.00 6 00 7 00 30.00 ADULTS & PEDIATRICS 1.00 481, 899 481, 899 0 1.00 2.00 50.00 OPERATING ROOM 933, 477 933, 477 0 0 2.00 60. 00 LABORATORY 3.00 9, 230 9, 230 0 0 0 3.00 69. 00 ELECTROCARDI OLOGY 0 4.00 5, 434 5 434 4.00 Ω 76. 00 ONCOLOGY 5.00 42, 877 42, 877 0 5.00 6.00 90. 00 CLI NI C 27,000 27,000 6.00 0 7.00 90. 01 WOUND CARE 96, 933 96, 933 0 7.00 91. 00 EMERGENCY 8.00 0 8.00 1, 344, 763 0 1, 344, 763 0 9.00 0.00 9.00 10.00 0.00 0 10.00 2, 941, 613 1, 380, 993 1,560,620 200.00 200.00 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 0 0 3.00 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 90. 01 WOUND CARE 0 0 7 00 7.00 0 91. 00 EMERGENCY 0 0 0 8.00 0 8.00 9.00 0.00 0 9.00 0 10.00 0.00 0 0 0 C 10.00 o 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 2.00 1.00 15.00 16.00 17.00 18.00 1.00 30. 00 ADULTS & PEDIATRICS 0 0 481, 899 1.00 50. 00 OPERATING ROOM 0 0 0 2.00 933, 477 2.00 0 3.00 60. 00 LABORATORY 0 0 3.00 69. 00 ELECTROCARDI OLOGY 0 4.00 5, 434 4.00 5.00 76. 00 ONCOLOGY 0 0 42, 877 5.00 6.00 90. 00 CLI NI C 0 0 6.00 οl 90. 01 WOUND CARE 0 7.00 7 00 0 96, 933 91. 00 EMERGENCY 0 0 8.00 0 0 8.00 9.00 0.00 0 0 9.00 0 0 10.00 0.00 0 10.00 1, 560, 620 200.00 200.00

| Period: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1305

				Ť	09/30/2023		
			CAPI TAL			2/27/2024 9: 3	Z dili
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
		for Cost	FLXT	BENEFITS		E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7) 0	1.00	4.00	4A	5. 00	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	2, 117, 158	2, 117, 158				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 701, 723					4.00
	00500 ADMINISTRATIVE & GENERAL	6, 099, 770					5. 00
	00700 OPERATION OF PLANT	1, 812, 677	184, 234				7.00
	00800 LAUNDRY & LI NEN SERVI CE	78, 485					8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	371, 183 363, 300					9. 00 10. 00
13. 00	01300 NURSING ADMINISTRATION	474, 331	13, 078				ł
	01400 CENTRAL SERVI CES & SUPPLY	54, 607	27, 648				1
	01500 PHARMACY	0					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	334, 252	45, 144	93, 560	472, 956	113, 133	16. 00
17.00	01700 SOCI AL SERVI CE	53, 584	0	15, 450	69, 034	16, 513	17. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS	1 (50 017	0.0.5.7		0 405 000	50, 0,0	
	03000 ADULTS & PEDIATRICS	1, 659, 917	260, 567				30.00
	03100   INTENSIVE CARE UNIT   04300   NURSERY	0	0 0			_	31.00 43.00
43.00	ANCILLARY SERVICE COST CENTERS	0			0		43.00
50.00	05000 OPERATING ROOM	749, 172	160, 272	455, 608	1, 365, 052	326, 527	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	1				52.00
53.00	05300 ANESTHESI OLOGY	7, 182	907	0	8, 089	1, 935	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 327, 920	•			421, 483	54.00
	06000 LABORATORY	1, 599, 102	40, 639			446, 211	60.00
	06001 BLOOD LABORATORY	0	0	1		-	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	51, 349					63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	411, 450 1, 000, 212	22, 909 51, 756				65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	187, 109					67.00
68. 00	06800 SPEECH PATHOLOGY	193					68.00
69.00	06900 ELECTROCARDI OLOGY	8, 907	0	0			69.00
	06901 CARDIAC REHABILITATION	76, 115	13, 107	21, 017	110, 239	26, 370	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	_	0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	670, 039		0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	79, 676		0	,		72.00 73.00
	03020 ONCOLOGY	2, 505, 156 153, 604		24, 304 42, 753			76.00
	OUTPATIENT SERVICE COST CENTERS	155,004	10, 301	1 42,755	212,000	30, 717	70.00
	08800 RURAL HEALTH CLINIC	4, 845, 594	235, 025	1, 314, 060	6, 394, 679	1, 529, 633	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	773, 522	0	187, 880	961, 402	229, 972	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	235, 349	0	56, 437	291, 786	69, 797	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	662, 929		161, 180			88. 03
	09000 CLI NI C	263, 511	53, 102				1
	09001 WOUND CARE	277, 137					
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 753, 924	188, 594	361, 353	3, 303, 871 0		91.00 92.00
	OTHER REIMBURSABLE COST CENTERS					L	72.00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0					116. 00
118. 00	, ,	37, 760, 139	2, 103, 963	5, 616, 145	37, 636, 000	7, 224, 898	118. 00
	NONREIMBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		12 105	1 0	12 105	2.154	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 195 0				190. 00 190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	414, 049				114, 089	
	19201 KNOX RHC	0	0	02, 702	0		192. 01
	19202 RETAIL PHARMACY	21, 369	Ö	Ö	21, 369		192. 02
192. 03	19203 CULVER	268, 774	0	43, 610		74, 724	192. 03
	07950 MARKETI NG	38, 210	0	4, 432			
200.00			_	_	0		200.00
201.00		20 E00 E41	0 117 150	5 727 000	_		201.00
202. 00	TOTAL (sum lines 118 through 201)	38, 502, 541	2, 117, 158	5, 727, 089	38, 502, 541	7, 432, 179	<sub>1</sub> 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1305

Peri od: Worksheet B From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared:

2/27/2024 9:32 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE ADMI NI STRATI O PLANT Ν 7. 00 9.00 8 00 10 00 13 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 2, 612, 064 7.00 00800 LAUNDRY & LINEN SERVICE 147, 565 8.00 24,666 8.00 9.00 00900 HOUSEKEEPI NG 15, 381 569, 907 9.00 01000 DI ETARY 121,060 27, 706 789, 667 10.00 C 10.00 13.00 01300 NURSING ADMINISTRATION 17, 812 4,076 773, 989 13.00 14 00 01400 CENTRAL SERVICES & SUPPLY 37,657 0 8,618 0 0 14.00 01500 PHARMACY 30.883 7.068 15.00 15.00 0 0 0 01600 MEDICAL RECORDS & LIBRARY 16.00 61, 486 r 14,072 0 Λ 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 354, 891 30.032 81, 220 789, 667 423, 349 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04300 NURSERY 43 00 43.00 0 0 0 ANCILLARY SERVICE COST CENTERS 50 00 103, 109 05000 OPERATING ROOM 218, 290 35, 200 49, 958 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 05300 ANESTHESI OLOGY 0 53.00 1, 235 283 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 191, 790 25, 341 54.00 43.893 0 54.00 60.00 06000 LABORATORY 55, 349 357 12,667 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 2, 431 556 0 0 63.00 0 63.00 06500 RESPIRATORY THERAPY 7, 141 65.00 31, 201 18,024 65.00 66.00 06600 PHYSI CAL THERAPY 94, 202 25, 104 21, 559 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0 C 0 0 69.00 69.01 06901 CARDIAC REHABILITATION 17,852 0 4,086 0 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 0 0 0 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 Ω 0 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 O 73.00 C 0 03020 ONCOLOGY 76.00 22, 475 37 5, 143 0 42, 918 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 320, 102 2,300 73, 258 0 0 88.00 08801 RURAL HEALTH CLINIC II 0 88.01 155, 568 248 35,603 0 88.01 88 02 08802 RURAL HEALTH CLINIC III 65, 431 40 14.975 0 Ω 88.02 08803 RURAL HEALTH CLINIC IV 0 88.03 85, 714 C 19,616 0 88.03 90.00 09000 CLI NI C 72, 325 16, 552 0 19,880 90.00 90.01 09001 WOUND CARE 87, 945 3,012 20, 127 ol 90.01 0 09100 EMERGENCY 91 00 91 00 256, 863 25, 430 0 166, 709 58. 785 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE C 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 342, 609 147, 101 789, 667 773, 989 118. 00 118.00 526, 962 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 17.972 C 4, 113 190. 01 19001 HOMECARE 0 0 190.01 192.00 19200 PHYSICIANS' PRIVATE OFFICES 251, 483 378 38, 832 0 0 192.00 0 192. 01 19201 KNOX RHC 0 192. 01 0 C 0 192. 02 19202 RETAIL PHARMACY 0 r 0 0 0 192.02 192. 03 19203 CULVER 0 86 0 0 0 192.03 194. 00 07950 MARKETI NG 0 0 0 0 194.00 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 2, 612, 064 147, 565 569, 907 789, 667 773, 989 202. 00

Period: Worksheet B From 10/01/2022 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1305

				To	09/30/2023		pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	2/27/2024 9: 3 Subtotal	2 am
		14. 00	15. 00	16.00	17. 00	24.00	
1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00	GENERAL SERVICE COST CENTERS  00100 NEW CAP REL COSTS-BLDG & FIXT  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00700 OPERATION OF PLANT  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01000 DI ETARY  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDICAL RECORDS & LIBRARY	158, 525 0 0	66, 050 0	661, 647			1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00
17. 00	O1700   SOCIAL SERVICE     INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	85, 547		17.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0 0 0	0 0 0	14, 276 0 0	79, 837 0 0	4, 865, 361 0 0	30. 00 31. 00 43. 00
50. 00 52. 00 53. 00 54. 00 60. 01 63. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 76. 00 88. 01 88. 02 88. 03 90. 00 90. 01 91. 00 92. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM  05300 ANESTHESIOLOGY  05400 RADIOLOGY-DIAGNOSTIC  06000 LABORATORY  06001 BLOOD LABORATORY  06300 BLOOD STORING, PROCESSING & TRANS.  06500 RESPIRATORY THERAPY  06600 PHYSICAL THERAPY  06600 PHYSICAL THERAPY  06700 OCCUPATIONAL THERAPY  06800 SPEECH PATHOLOGY  06901 CARDIAC REHABILITATION  07000 ELECTROCARDIOLOGY  07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  07200 IMPL. DEV. CHARGED TO PATIENTS  07300 DRUGS CHARGED TO PATIENTS  03020 ONCOLOGY  0UTPATIENT SERVICE COST CENTERS  088001 RURAL HEALTH CLINIC III  08802 RURAL HEALTH CLINIC III  08803 RURAL HEALTH CLINIC IV  09000 CLINIC  09001 WOUND CARE  09100 EMERGENCY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58, 033 0 7, 134 167, 984 130, 109 0 1, 182 9, 064 27, 649 6, 030 0 5, 631 3, 092 0 22, 183 3, 373 81, 033 2, 178 44, 850 4, 799 819 5, 066 2, 795 7, 811 56, 556	5, 710 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 161, 879 0 18, 676 2, 612, 506 2, 510, 084 0 70, 013 737, 041 1, 820, 556 304, 191 239 16, 669 161, 639 0 992, 737 120, 395 3, 281, 602 336, 526  8, 364, 822 1, 387, 592 442, 848 1, 131, 636 527, 575 592, 752 4, 658, 516	52. 00 53. 00 54. 00 60. 01 63. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 88. 00 88. 01 88. 02
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100  HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
116. 00 118. 00	11600 HOSPI CE	0 158, 525	0 66, 050	0 661, 647	0 85, 547	0 37, 115, 855	116. 00 118. 00
190. 01 192. 00 192. 01 192. 02 192. 03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 HOMECARE 19200 PHYSICI ANS' PRIVATE OFFICES 19201 KNOX RHC 19202 RETAIL PHARMACY 19203 CULVER 07950 MARKETING Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	881, 733 0 26, 481 387, 194 52, 842 0	190. 01 192. 00 192. 01 192. 02 192. 03 194. 00 200. 00 201. 00

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

From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/27/2024 9:32 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 4, 865, 361 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 C 04300 NURSERY 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 2, 161, 879 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 52.00 0 05300 ANESTHESI OLOGY 53.00 18, 676 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 612, 506 54.00 06000 LABORATORY 60.00 2, 510, 084 60.00 60 01 06001 BLOOD LABORATORY 60 01 Ω 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 70,013 63.00 65.00 06500 RESPIRATORY THERAPY 737, 041 65.00 06600 PHYSI CAL THERAPY 66.00 1,820,556 66.00 06700 OCCUPATI ONAL THERAPY 67 00 304, 191 67 00 06800 SPEECH PATHOLOGY 68.00 239 68.00 06900 ELECTROCARDI OLOGY 16, 669 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 161, 639 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 992, 737 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 120, 395 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 281, 602 73.00 03020 ONCOLOGY 0 336, 526 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 8, 364, 822 88.00 08801 RURAL HEALTH CLINIC II 0 1, 387, 592 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 442, 848 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 1, 131, 636 88.03 0 90.00 09000 CLI NI C 527, 575 90.00 09001 WOUND CARE 592, 752 90.01 90.01 91.00 09100 EMERGENCY 0 4, 658, 516 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 37, 115, 855 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 38, 436 190.00 0 190. 01 19001 HOMECARE 190.01 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 881, 733 0 192. 01 19201 KNOX RHC 192.01 192. 02 19202 RETAIL PHARMACY 0 0 0 192. 02 26, 481 192. 03 19203 CULVER 387, 194 192. 03 194. 00 07950 MARKETI NG 194.00 52, 842 200.00 Cross Foot Adjustments C 200.00 0 201.00 Negative Cost Centers 201.00 202.00 202 00 TOTAL (sum lines 118 through 201) 38, 502, 541

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305

					To	09/30/2023	Date/Time Pre 2/27/2024 9:3	
				CAPI TAL			2/2//2024 7. 3	Z dili
		Cost Center Description	Dimontly	RELATED COSTS	Cubtotal	EMDL OVEE	ADMINICTDATIV	
		cost center bescription	Directly Assigned New	NEW BLDG & FLXT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIV E & GENERAL	
			Capi tal			DEPARTMENT		
			Related Costs	1.00	0.4	4.00	F 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2A	4. 00	5. 00	
1.00		NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	25, 366		25, 366		4. 00
5.00	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	0	416, 980		4, 056 492	421, 036	5. 00 7. 00
7. 00 8. 00	1	LAUNDRY & LINEN SERVICE	0	184, 234 18, 110		492 11	28, 564 1, 344	8.00
9. 00	00900	HOUSEKEEPI NG	0	11, 293		288	6, 064	•
10.00		DI ETARY	0	88, 884		288	7, 008	1
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	13, 078 27, 648		530 37	8, 224 1, 227	13. 00 14. 00
15. 00		PHARMACY	o o	22, 675		0	307	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	45, 144		415	6, 409	16. 00
17. 00		SOCIAL SERVICE  ENT ROUTINE SERVICE COST CENTERS	0	0	0	68	935	17. 00
30. 00		ADULTS & PEDIATRICS	0	260, 567	260, 567	2, 547	33, 813	30.00
31.00		INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00		NURSERY	0	0	0	0	0	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	160, 272	160, 272	2, 019	18, 498	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	Ö	0		0	0	52.00
53.00		ANESTHESI OLOGY	0	907		0	110	ł
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	0	140, 816 40, 639		1, 299 1, 000	23, 877 25, 278	54. 00 60. 00
60. 01		BLOOD LABORATORY	Ö	0		0	25, 270	60.01
63.00		BLOOD STORING, PROCESSING & TRANS.	0	1, 785		0	720	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	22, 909 51, 756		477 1, 246	7, 344 18, 065	1
67.00		OCCUPATI ONAL THERAPY	0	0 31, 730	_	237	3, 260	1
68.00		SPEECH PATHOLOGY	0	0	0	0	3	68.00
69.00	1	ELECTROCARDI OLOGY	0	0	0	0	121	69.00
69. 01 70. 00		CARDI AC REHABI LI TATI ON ELECTROENCEPHALOGRAPHY	0	13, 107 0		93 0	1, 494 0	69. 01 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	0	0	9, 080	•
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1, 080	1
73. 00 76. 00		DRUGS CHARGED TO PATIENTS ONCOLOGY	0	16, 501	16, 501	108 189	34, 277 2, 884	73. 00 76. 00
70.00		TIENT SERVICE COST CENTERS		10, 301	10, 301	107	2,004	70.00
88. 00		RURAL HEALTH CLINIC	0	235, 025		5, 812	86, 655	88. 00
88. 01 88. 02		RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III	0	0	0	832 250	13, 028 3, 954	•
88. 03		RURAL HEALTH CLINIC IV	0	Ö	0	714	11, 168	1
90.00		CLINIC	0	53, 102		85	4, 549	
90. 01		WOUND CARE EMERGENCY	0	64, 571 188, 594		180 1, 601	5, 182 44, 771	1
		OBSERVATION BEDS (NON-DISTINCT PART)	0	100, 394	100, 394	1, 601	44,771	91.00
	OTHER	REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
116. 00		AL PURPOSE COST CENTERS HOSPI CE	0	0	0	0	0	116. 00
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 103, 963	2, 103, 963	24, 874		
100.00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 195	13, 195	0	170	190. 00
		HOMECARE	0	13, 143	13, 143	0		190.00
		PHYSICIANS' PRIVATE OFFICES	0	0	0	279	•	192. 00
		KNOX RHC	0	0	0	0		192. 01 192. 02
		RETAIL PHARMACY CULVER	0	0		193		192. 02
194.00	07950	MARKETI NG	0	0	o	20		194. 00
200.00	1	Cross Foot Adjustments		_	0	-	_	200.00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0 2, 117, 158	0 2, 117, 158	0 25, 366		201. 00 202. 00
_02.00	1	(Sam 11.05 110 till bugil 201)	,	2, 117, 130	2, 117, 150	25, 500	121,030	

Provider CCN: 15-1305

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part II
To 09/30/2023 Date/Time Prepared: 2/27/2024 9:32 am

				077 307 2023	2/27/2024 9: 3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	PLANT	LINEN SERVICE			ADMI NI STRATI O	
					N	
	7. 00	8. 00	9. 00	10. 00	13. 00	
GENERAL SERVICE COST CENTERS	I		ı			
1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00   00500   ADMI NI STRATI VE & GENERAL	040.000					5.00
7. 00   00700   OPERATION OF PLANT	213, 290	04 470				7.00
8. 00   00800   LAUNDRY & LINEN SERVICE	2, 014	21, 479				8.00
9. 00   00900   HOUSEKEEPI NG	1, 256	0	18, 901	10/ 004		9.00
10. 00 01000 DI ETARY	9, 885	0	919	106, 984	00 404	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 454	0	135	0	23, 421	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	3, 075	0	286	0	0	14.00
15. 00   01500   PHARMACY	2, 522	0	234	0	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	5, 021	0	467	0	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	20, 070	4 071	2 (02	107 004	10.010	20.00
30. 00   03000   ADULTS & PEDI ATRI CS	28, 979	4, 371	2, 692	106, 984	12, 810	30.00
31. 00   03100   NTENSIVE CARE UNIT	0 0	0		0	0	31.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43. 00
50. 00 05000 OPERATING ROOM	17, 825	5, 123	1, 657	0	3, 120	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	17, 825	5, 123	1,657	0	3, 120	52.00
53. 00   05300   ANESTHESI OLOGY	101	0	9	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	15, 661	3, 689	1	0	0	54.00
60. 00   06000   LABORATORY	4, 520	52		0	0	60.00
60. 01   06001   BLOOD LABORATORY	4, 320	0		0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	198	0	18	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	2, 548	0	237	0	545	65.00
66. 00 06600 PHYSI CAL THERAPY	7, 692	3, 654	715	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0,001	, 10	0	ő	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	ő	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	Ö	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	1, 458	0	135	0	ő	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	Ö	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	ő	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	l o	0	0	73. 00
76. 00 03020 0NC0L0GY	1, 835	5	171	0	1, 299	76. 00
OUTPATIENT SERVICE COST CENTERS	,					
88. 00 08800 RURAL HEALTH CLINIC	26, 138	335	2, 430	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	12, 703	36	1, 181	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	5, 343	6	497	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	6, 999	0	651	0	0	88. 03
90. 00   09000   CLI NI C	5, 906	0	549	0	602	90.00
90. 01   09001   WOUND CARE	7, 181	438	668	0	0	90. 01
91. 00 09100 EMERGENCY	20, 974	3, 702	1, 950	0	5, 045	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	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	191, 288	21, 411	17, 477	106, 984	23, 421	118. 00
NONREI MBURSABLE COST CENTERS	1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 467	0	136	0		190. 00
190. 01 19001 HOMECARE	0	0		0		190. 01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	20, 535	55		0		192. 00
192.01 19201 KNOX RHC	0	0		0		192. 01
192. 02 19202 RETAIL PHARMACY	0	0	-	0		192. 02
192. 03 19203 CULVER	0	13		0		192. 03
194. 00 07950 MARKETI NG	0	0	0	0		194. 00
200.00 Cross Foot Adjustments						200. 00
201. 00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	213, 290	21, 479	18, 901	106, 984	23, 421	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1305

					To	09/30/2023	Date/Time Pre	
		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	2/27/2024 9: 3 Subtotal	2 alli
			SERVICES &		RECORDS &	SERVI CE		
			SUPPLY		LI BRARY			
	CENED	AL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	24. 00	
1. 00		NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	1 1	ADMINISTRATIVE & GENERAL						5.00
7.00	1 .	OPERATION OF PLANT						7. 00
8. 00		LAUNDRY & LINEN SERVICE						8.00
9.00		HOUSEKEEPI NG						9.00
10. 00 13. 00		DI ETARY NURSI NG ADMI NI STRATI ON						10.00 13.00
14. 00		CENTRAL SERVICES & SUPPLY	32, 273					14.00
15. 00		PHARMACY	02, 2, 0	25, 738				15.00
16.00		MEDICAL RECORDS & LIBRARY	0	0	57, 456			16.00
17. 00	01700	SOCIAL SERVICE	0	0	0	1, 003		17.00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDI ATRI CS	0	0		936	454, 938	30.00
31.00	1	INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	0	0	U <sub>I</sub>	0	43.00
50. 00		OPERATING ROOM	0	0	5, 036	67	213, 617	50.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	0	0,000	0	0	52.00
53.00		ANESTHESI OLOGY	0	0	619	0	1, 746	1
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	0	14, 613	0	201, 411	54.00
60.00	1 1	LABORATORY	0	0	11, 292	0	83, 201	1
60. 01		BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	1 1	BLOOD STORING, PROCESSING & TRANS.	0	0	103	0	2, 824	1
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	787 2, 400	0	34, 847 85, 528	65. 00 66. 00
67. 00		OCCUPATI ONAL THERAPY	0	0	523	0	4, 020	67.00
68. 00		SPEECH PATHOLOGY	o	0	0	o	3	68.00
69.00	06900	ELECTROCARDI OLOGY	О	0	489	0	610	69.00
69. 01	06901	CARDIAC REHABILITATION	0	0	268	0	16, 555	69. 01
70. 00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 550	0	1, 925	0	39, 555	1
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	3, 723 0	0 25, 738	293 7, 032	0	5, 096 67, 155	•
76.00		ONCOLOGY	0	25, 736		0	23, 073	1
70.00		TIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	107	<u> </u>	20,010	70.00
88. 00		RURAL HEALTH CLINIC	0	0	3, 892	0	360, 287	88. 00
88. 01	1	RURAL HEALTH CLINIC II	0	0	416	0	28, 196	88. 01
88. 02	1	RURAL HEALTH CLINIC III	0	0	71	0	10, 121	88. 02
88. 03		RURAL HEALTH CLINIC IV	0	0	440	0	19, 972	1
90. 00 90. 01		CLINIC WOUND CARE	0	0	243 678	0	65, 036 78, 898	1
91.00		EMERGENCY	0	0	4, 908	0	271, 545	1
92. 00	1 .	OBSERVATION BEDS (NON-DISTINCT PART)	Ŭ.	J	1, 700	Ĭ	271,010	92.00
		REIMBURSABLE COST CENTERS			!	'		
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101.00
		AL PURPOSE COST CENTERS	. 1					
		HOSPI CE	0	0		0		116.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	32, 273	25, 738	57, 456	1, 003	2, 068, 234	1118.00
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	14, 977	190 00
		HOMECARE	o	0		o		190. 01
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192. 01	19201	KNOX RHC	0	0	0	0	0	192. 01
		RETALL PHARMACY	0	0	0	0		192. 02
		CULVER	0	0	0	0		192.03
194. 00 200. 00		MARKETING Cross Foot Adjustments	O	0	0	O		194. 00 200. 00
200.00		Negative Cost Centers	n	0	0	0		200.00
202.00		TOTAL (sum lines 118 through 201)	32, 273	25, 738	57, 456	1, 003	2, 117, 158	
	1		-2, 2, 0	_5,.50		., 550	-, ,	

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305 Peri od: Worksheet B From 10/01/2022 Part II 09/30/2023 Date/Time Prepared: 2/27/2024 9:32 am 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 0 454, 938 30.00 03100 INTENSIVE CARE UNIT 0 31.00 C 31.00 04300 NURSERY 43.00 0 43.00 Ω ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 213, 617 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 52.00 05300 ANESTHESI OLOGY 1, 746 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 201, 411 54.00 06000 LABORATORY 60.00 83, 201 60.00 60 01 06001 BLOOD LABORATORY 60 01 C 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 2,824 63.00 65.00 06500 RESPIRATORY THERAPY 34, 847 65.00 06600 PHYSI CAL THERAPY 66.00 85, 528 66.00 06700 OCCUPATI ONAL THERAPY 67 00 4,020 67 00 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 610 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 16, 555 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 39, 555 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 5,096 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 67, 155 73.00 03020 ONCOLOGY 0 76.00 23, 073 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 360, 287 88.00 0 08801 RURAL HEALTH CLINIC II 88.01 28, 196 88.01 08802 RURAL HEALTH CLINIC III 88.02 10, 121 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 0 19, 972 88.03 90.00 09000 CLI NI C 65, 036 90.00 09001 WOUND CARE 90.01 90.01 78, 898 91.00 09100 EMERGENCY 0 271, 545 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 2,068,234 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 14, 977 190.00 0 190. 01 19001 HOMECARE 190.01 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 00000 192. 00 28, 620 192. 01 19201 KNOX RHC C 192.01 192. 02 19202 RETAIL PHARMACY 192. 02 290 192. 03 19203 CULVER 192. 03 4.439

598

2, 117, 158

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C

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194.00

200.00

201.00 202.00

194. 00 07950 MARKETI NG

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202 00

COST AI	LOCATION - STATISTICAL BASIS						
			Provider C	F	eriod: rom 10/01/2022 o 09/30/2023	Worksheet B-1 Date/Time Pre 2/27/2024 9:3	epared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS	70.040		T			
4. 00 5. 00 7. 00 8. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	72, 363 867 14, 252 6, 297 619	19, 855, 557 3, 173, 746 384, 638 8, 949	-7, 432, 179 0 0	2, 107, 855 99, 176	65, 550 619	8.00
	00900 HOUSEKEEPI NG	386	225, 382		447, 485	386	1
	01000 DIETARY 01300 NURSING ADMINISTRATION	3, 038 447	225, 361 414, 344	0		3, 038 447	1
	01400 CENTRAL SERVICES & SUPPLY	945	28, 870			945	1
	01500 PHARMACY	775	0	0	22, 675	775	1
	01600 MEDICAL RECORDS & LIBRARY	1, 543	324, 369			1, 543	1
	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	53, 566	0	69, 034	0	17. 00
	03000 ADULTS & PEDIATRICS	8, 906	1, 992, 580	0	2, 495, 220	8, 906	30.00
	03100 INTENSIVE CARE UNIT	0	0			0	
	04300 NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	5, 478	1, 579, 571	0	1, 365, 052	5, 478	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0, 1, 0	0	Ö		0, 170	1
53.00	05300 ANESTHESI OLOGY	31	0	0		31	1
	05400 RADI OLOGY-DI AGNOSTI C	4, 813	1, 016, 783	0	,	4, 813	
	06000 LABORATORY 06001 BLOOD_LABORATORY	1, 389 0	782, 317 0	0	1, 865, 391 0	1, 389 0	1
	06300 BLOOD STORING, PROCESSING & TRANS.	61	Ö	Ö	-	61	1
	06500 RESPI RATORY THERAPY	783	373, 077			783	1
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 769 0	974, 835 185, 476		1, 333, 147 240, 607	2, 364 0	
	06800 SPEECH PATHOLOGY		185, 470			0	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	8, 907	0	
	06901 CARDI AC REHABI LI TATI ON	448	72, 864		, =	448	1
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	Ö		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	84, 262			0	1
	03020 ONCOLOGY	564	148, 223	0	212, 858	564	76. 00
	DUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	8, 033	4, 555, 803	0	6, 394, 679	8, 033	88. 00
	08801 RURAL HEALTH CLINIC II	0	651, 370			3, 904	88. 01
	08802 RURAL HEALTH CLINIC III	0	195, 664				88. 02
	08803 RURAL HEALTH CLINIC IV 09000 CLINIC	0 1, 815	558, 804 66, 235			2, 151 1, 815	88. 03 90. 00
	09001 WOUND CARE	2, 207	141, 037			2, 207	1
91.00	09100 EMERGENCY	6, 446	1, 252, 793	0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY	O	0	0	O	0	101.00
	SPECIAL PURPOSE COST CENTERS	-	·	_	-1	_	
118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	71, 912	19, 470, 919				116. 00 118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	13, 195	451	190. 00
	19001 HOMECARE	0	0	0			190. 01
	19200 PHYSICIANS' PRIVATE OFFICES 19201 KNOX RHC	0	218, 079	0			192. 00 192. 01
	19202 RETAIL PHARMACY	0	0				192.02
	19203 CULVER	0	151, 193		,		192. 03
	07950 MARKETI NG	0	15, 366	0	42, 642	0	194.00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 117, 158	5, 727, 089		7, 432, 179	2, 612, 064	
	Part I)						
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	29. 257466	0. 288438 25, 366		0. 239205 421, 036	39. 848421 213, 290	
205.00	Unit cost multiplier (Wkst. B, Part		0. 001278		0. 013551	3. 253852	205. 00
203.00	[11]	1		İ	1		1

Health Financial Sy	stems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - S	STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					rom 10/01/2022 o 09/30/2023		pared: 2 am
		CAPI TAL					
		RELATED COSTS					
Cost Ce	enter Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		FI XT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1 221)	SALARI ES)		0031)	1 221)	
		1. 00	4.00	5A	5. 00	7. 00	
	nit cost multiplier (Wkst. D, II and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 10/01/2022	Worksheet B-1	
				0 09/30/2023		
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	2/27/2024 9: 3 CENTRAL	2 am
	LINEN SERVICE	(SQUARE	(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	
GENERAL SERVICE COST CENTERS	1			I		1 1 00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT   4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE	111, 175	(2, 402				8.00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	0	62, 492 3, 038	100			9. 00 10. 00
13. 00   01300   NURSI NG   ADMI NI STRATI ON	o	447	0	74, 247		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	945	0	0	3, 593, 868	14.00
15. 00   01500   PHARMACY	0	775	0	0	0	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE		1, 543 0	0	_	0	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<sub>0</sub>		<u> </u>	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	22, 626	8, 906	100	40, 611	0	30.00
31. 00   03100   INTENSIVE CARE UNIT	0	0	0		0	31.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
50. 00 OPERATING ROOM	26, 519	5, 478	0	9, 891	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o	0	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	19, 092	31	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	19, 092	4, 813 1, 389	0	0	0	54. 00 60. 00
60. 01 06001 BLOOD LABORATORY	0	0	0	o	Ö	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	61	0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	783	0	1, 729	0	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	18, 913	2, 364	0	0	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	o	o	0	Ö	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	o	0	0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	448	0	0	0	69.01
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	3, 179, 285	70.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	o o	Ö	0	Ö	414, 583	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	0		0	73.00
76. 00 03020 ONCOLOGY	28	564	0	4, 117	0	76.00
0UTPATIENT SERVICE COST CENTERS  88. 00   08800   RURAL   HEALTH   CLINIC	1, 733	8, 033	0	0	0	88.00
88. 01   08801 RURAL HEALTH CLINIC II	187	3, 904	0	0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	30	1, 642	0	0	0	88. 02
88. 03   08803   RURAL HEALTH CLINIC IV 90. 00   09000   CLINIC	0	2, 151	0	1 007	0	88. 03 90. 00
90. 00   09000   CETNIC 90. 01   09001   WOUND CARE	2, 269	1, 815 2, 207	0	1, 907 0	0	90.00
91. 00 09100 EMERGENCY	19, 159	6, 446	0	15, 992	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY	O	ol	0	O	0	101. 00
SPECIAL PURPOSE COST CENTERS	J 0			0	0	1101.00
116. 00 11600 HOSPI CE	0	0	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	110, 825	57, 783	100	74, 247	3, 593, 868	118.00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	451	0	O	0	190. 00
190. 01 19001 HOMECARE	o	0	0			190.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	285	4, 258	0	0		192. 00
192. 01 19201 KNOX RHC	0	0	0	0		192.01
192. 02 19202  RETALL PHARMACY 192. 03 19203  CULVER	65	0	0	0		192. 02 192. 03
194. 00 07950 MARKETI NG	0	o	0	o		194.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	4.47. 5.45	F/0 007	700 //7	770 000	450 505	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	147, 565	569, 907	789, 667	773, 989	158, 525	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 327322	9. 119679	7, 896. 670000	10. 424515	0. 044110	203. 00
204.00 Cost to be allocated (per Wkst. B,	21, 479	18, 901	106, 984		32, 273	•
Part II)	0.400005	0.00015	1 0/0 0:00==	0.0154:-	0 00005	205 25
205.00 Unit cost multiplier (Wkst. B, Part	0. 193200	0. 302455	1, 069. 840000	0. 315447	0. 008980	205.00
206.00 NAHE adjustment amount to be allocated	1					206. 00
(per Wkst. B-2)						
NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	1				<u> </u>	l

Provider CCN: 15-1305

| Peri od: | Worksheet B-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: | Dat

				Τ	To 09/30/2023 Date/Time F 2/27/2024 9	
	Cost Center Description	PHARMACY (100%)	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE (ALLOCATI ON	2/2//2024	7. JZ dill
			(GROSS	OF TIME)		
		15.00	CHARGES)	17.00		
	GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE					7. 00 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	100				14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	100	81, 328, 541			15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	01, 320, 341	9, 888	3	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	,		,	1	
30. 00	03000 ADULTS & PEDIATRICS	0	1, 754, 877	9, 228		30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	C		31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		)	43.00
50. 00	05000 OPERATING ROOM	0	7, 133, 687	660		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	Ö	0	000		52.00
53.00	05300 ANESTHESI OLOGY	0	876, 925	c		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	20, 644, 903	C		54.00
60.00	06000 LABORATORY	0	15, 993, 763			60.00
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	145, 337			60. 01
65. 00	06500 RESPIRATORY THERAPY	0	1, 114, 180			65.00
66.00	06600 PHYSI CAL THERAPY	0	3, 398, 821	Ċ		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	741, 197	C		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	C		68.00
69. 00 69. 01	06900  ELECTROCARDI OLOGY   06901  CARDI AC REHABI LI TATI ON	0	692, 182 380, 137			69. 00 69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0.00, 137			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	2, 726, 839	d		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	414, 583	C		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	100	9, 960, 981			73.00
76. 00	03020   ONCOLOGY   OUTPATIENT SERVICE COST CENTERS	0	267, 732		)	76.00
88. 00	08800 RURAL HEALTH CLINIC	0	5, 513, 229	C		88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	589, 883	C		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	100, 633	C	D	88. 02
88. 03 90. 00	08803 RURAL HEALTH CLINIC IV	0	622, 744			88. 03
90.00	09000 CLI NI C 09001 WOUND CARE	0	343, 570 960, 119			90.00
91.00	09100 EMERGENCY	0	6, 952, 219			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	OTHER REIMBURSABLE COST CENTERS				-	
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0		)	101.00
116 00	11600 HOSPI CE	0	0	C		116.00
118.00		100	81, 328, 541	9, 888		118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C		190.00
	19001 HOMECARE  19200 PHYSICIANS'PRIVATE OFFICES	0	0			190. 01
	19200  PHYSICIANS   PRIVATE OFFICES	0	0			192. 00 192. 01
	19202 RETAIL PHARMACY		0			192.01
192. 03	19203 CULVER		0	Č		192. 03
	07950 MARKETI NG	0	0	(	D	194.00
200.00						200. 00 201. 00
201.00		66, 050	661, 647	85, 547	7	202.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I)	660. 500000 25, 738	0. 008135 57, 456	8. 651598 1, 003		203. 00 204. 00
205. 00		257. 380000	0. 000706	0. 10143 <i>6</i>	5	205.00
206.00						206.00
207. 00	(per Wkst. B-2)  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: From 10/01/2022 To 09/30/2023 Worksheet C Part I Date/Time Prepared:

					To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
			Title	XVIII	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						
	03000 ADULTS & PEDIATRICS	4, 865, 361		4, 865, 36			30.00
31.00	03100 INTENSIVE CARE UNIT	0			0		31.00
43.00	04300 NURSERY	0			0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS	,					
	05000 OPERATING ROOM	2, 161, 879		2, 161, 87			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	_	52.00
53.00	05300 ANESTHESI OLOGY	18, 676		18, 67		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 612, 506		2, 612, 50		0	54.00
60.00	06000 LABORATORY	2, 510, 084		2, 510, 08	4 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	70, 013		70, 01		0	63.00
65. 00	06500 RESPI RATORY THERAPY	737, 041	0	737, 04		0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 820, 556	0	1, 820, 55	6 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	304, 191	0	304, 19	1 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	239	0	23	9 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	16, 669		16, 66	9 0	0	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	161, 639		161, 63	9 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	992, 737		992, 73	7 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	120, 395		120, 39	5 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 281, 602		3, 281, 60	2 0	0	73.00
76.00	03020 ONCOLOGY	336, 526		336, 52	6 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	8, 364, 822		8, 364, 82	2 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 387, 592		1, 387, 59	2 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	442, 848		442, 84	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	1, 131, 636		1, 131, 63		0	88. 03
90.00	09000  CLI NI C	527, 575		527, 57	5 0	0	90.00
90. 01	09001 WOUND CARE	592, 752		592, 75	2 0	0	90. 01
91.00	09100 EMERGENCY	4, 658, 516		4, 658, 51	6 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 691, 814		1, 691, 81	4	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0			0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0			0		116. 00
200.00	1 1	38, 807, 669	0	38, 807, 66	9 0		200. 00
201.00		1, 691, 814		1, 691, 81			201. 00
202.00	Total (see instructions)	37, 115, 855	0	37, 115, 85	5 0	0	202. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Period: Worksheet C From 10/01/2022 Part I
		To 09/30/2023 Date/Time Prepared

					From 10/01/2022 To 09/30/2023	Part I Date/Time Pre 2/27/2024 9:3	pared: 2 am
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		T			
30.00	03000 ADULTS & PEDIATRICS	1, 129, 113		1, 129, 113			30.00
31. 00	03100 INTENSIVE CARE UNIT	0		(			31.00
43.00	04300 NURSERY	0		(			43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00		543, 586	6, 590, 101			0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0. 000000	
53.00	05300 ANESTHESI OLOGY	29, 279	847, 646			0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 150, 208	19, 494, 695			0. 000000	54.00
60.00	06000 LABORATORY	1, 725, 492	14, 268, 271	15, 993, 763		0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(	0.00000	0. 000000	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	41, 210	104, 127			0. 000000	63.00
65.00	06500 RESPI RATORY THERAPY	510, 530	603, 650	1, 114, 180	0. 661510	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	362, 024	3, 036, 797	3, 398, 821	0. 535643	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	204, 143	537, 054	741, 197	0. 410405	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0.000000	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	18, 504	673, 678	692, 182	0. 024082	0.000000	69.00
69. 01	06901 CARDIAC REHABILITATION	0	380, 137	380, 137	0. 425212	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0.000000	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	774, 472	1, 952, 367	2, 726, 839	0. 364061	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	64, 176	350, 407	414, 583	0. 290400	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 085, 897	4, 875, 084	9, 960, 981	0. 329446	0.000000	73.00
76.00	03020 ONCOLOGY	564	267, 168	267, 732	1. 256951	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	5, 513, 229	5, 513, 229			88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	589, 883	589, 883	3		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	100, 633	100, 633	3		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	622, 744	622, 744	1		88. 03
90.00	09000 CLI NI C	0	343, 570	343, 570	1. 535568	0.000000	90.00
90. 01	09001 WOUND CARE	2, 391	957, 728	960, 119	0. 617373	0.000000	90. 01
91.00	09100 EMERGENCY	309, 289	6, 642, 930	6, 952, 219	0. 670076	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	625, 764	625, 764	2. 703598	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	0	(			101.00
	SPECIAL PURPOSE COST CENTERS						1
116.00	11600 HOSPI CE	0	0	(			116. 00
200.00		11, 950, 878	69, 377, 663	81, 328, 541			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	11, 950, 878	69, 377, 663	81, 328, 541			202. 00

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 15-1305	From 10/01/2022	Worksheet C Part I Date/Time Prepared:

					2/27/2024 9: 3	2 am
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
	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
	06901 CARDI AC REHABI LI TATI ON	0. 000000				69. 01
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
	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	<u> </u>				
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
90. 01	09001 WOUND CARE	0. 000000				90. 01
91.00	09100 EMERGENCY	0. 000000				91.00
	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						200.00
201.00						201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	PULASKI ME	MORIAL HOSPITAL		In Lieu	u of Form CMS-25	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-1305	From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Prepa 2/27/2024 9:32	
		Ti	tle XIX	Hospi tal	Cost	

				T	o 09/30/2023	Date/Time Pre 2/27/2024 9:3	
			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	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 865, 361		4, 865, 361	0	4, 865, 361	30.00
	03100 INTENSIVE CARE UNIT	0		0		0	
	04300 NURSERY	0		0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS	0.4/4.070		0.4/4.070		0.4/4.070	
	05000 OPERATING ROOM	2, 161, 879		2, 161, 879		2, 161, 879	•
	D5200 DELIVERY ROOM & LABOR ROOM	0		10 (7)	0	0	52.00
	05300 ANESTHESI OLOGY	18, 676		18, 676		18, 676	•
4	05400 RADI OLOGY-DI AGNOSTI C	2, 612, 506		2, 612, 506		2, 612, 506	•
	06000 LABORATORY	2, 510, 084		2, 510, 084		2, 510, 084	•
	06001 BLOOD LABORATORY	70.010		70 010	١	70.010	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	70, 013		70, 013		70, 013	•
	06500 RESPI RATORY THERAPY	737, 041	0	737, 041		737, 041	•
	06600 PHYSI CAL THERAPY	1, 820, 556	0	1, 820, 556		1, 820, 556	1
	06700 OCCUPATI ONAL THERAPY	304, 191	0	304, 191		304, 191	67.00
	06800 SPEECH PATHOLOGY	239	0	239		239	68.00
	06900 ELECTROCARDI OLOGY	16, 669		16, 669		16, 669	•
	06901 CARDI AC REHABI LI TATI ON	161, 639		161, 639		161, 639	•
	07000 ELECTROENCEPHALOGRAPHY	0		000 707		000 707	
4	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	992, 737		992, 737		992, 737	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	120, 395		120, 395		120, 395	1
	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	3, 281, 602		3, 281, 602		3, 281, 602	
	DUTPATIENT SERVICE COST CENTERS	336, 526		336, 526	l ol	336, 526	76. 00
	D8800 RURAL HEALTH CLINIC	8, 364, 822		8, 364, 822	l ol	8, 364, 822	88. 00
	D8801 RURAL HEALTH CLINIC II	1, 387, 592				1, 387, 592	1
	08802 RURAL HEALTH CLINIC III	442, 848		1, 387, 592 442, 848		442, 848	
	D8803 RURAL HEALTH CLINIC IV					·	•
	09000 CLINIC	1, 131, 636 527, 575		1, 131, 636 527, 575		1, 131, 636 527, 575	
	09001 WOUND CARE	527, 575 592, 752		592, 752		592, 752	
	09100 EMERGENCY	4, 658, 516		4, 658, 516		4, 658, 516	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 691, 814		1, 691, 814		1, 691, 814	
	OTHER REIMBURSABLE COST CENTERS	1,091,014		1,091,014		1,091,014	92.00
	10100 HOME HEALTH AGENCY	ol		С		0	101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>				0	1101.00
	11600 HOSPI CE	0		0		Ω	116.00
200.00	Subtotal (see instructions)	38, 807, 669	0	1		38, 807, 669	
201.00	Less Observation Beds	1, 691, 814	· ·	1, 691, 814	l .	1, 691, 814	
202.00	Total (see instructions)	37, 115, 855	0		l .	37, 115, 855	
	1 (=== :::==:========================	21, 112, 000	· ·		۱ ۹	,, 000	

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1	From 10/01/2022 Part I
		To 09/30/2023 Date/Time Prepared:

					To 09/30/2023	Date/Time Pre 2/27/2024 9:3	epared: 32 am
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	1, 129, 113		1, 129, 113	3		30.00
31.00	03100 INTENSIVE CARE UNIT	0		(			31.00
43.00	04300 NURSERY	0		(			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	543, 586	6, 590, 101	7, 133, 68	0. 303052	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0.000000	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	29, 279	847, 646	876, 925	0. 021297	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 150, 208	19, 494, 695	20, 644, 903	0. 126545	0.000000	54.00
60.00	06000 LABORATORY	1, 725, 492	14, 268, 271	15, 993, 763	0. 156941	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0. 000000	0.000000	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	41, 210	104, 127	145, 33	0. 481729	0. 000000	63.00
65. 00	06500 RESPIRATORY THERAPY	510, 530	603, 650	1, 114, 180	0. 661510	0.000000	65.00
	06600 PHYSI CAL THERAPY	362, 024	3, 036, 797			0. 000000	
	06700 OCCUPATI ONAL THERAPY	204, 143	537, 054			0. 000000	1
	06800 SPEECH PATHOLOGY	0	007,007			0. 000000	
	06900 ELECTROCARDI OLOGY	18, 504	673, 678			0. 000000	
	06901 CARDI AC REHABI LI TATI ON	10,001	380, 137			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY		000, 107			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	774, 472	1, 952, 367			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	64, 176	350, 407			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	5, 085, 897	4, 875, 084			0. 000000	
	03020 ONCOLOGY	564	267, 168			0. 000000	
	OUTPATIENT SERVICE COST CENTERS	304	207, 100	201, 132	1. 230 73 1	0.000000	70.00
	08800 RURAL HEALTH CLINIC		5, 513, 229	5, 513, 229	1. 517227	0. 000000	88. 00
	08801 RURAL HEALTH CLINIC II		589, 883			0. 000000	
	08802 RURAL HEALTH CLINIC III		100, 633			0. 000000	
	08803 RURAL HEALTH CLINIC IV	0	622, 744			0. 000000	
	09000 CLINIC		· ·			0.00000	
	09000 CETNIC 09001 WOUND CARE	2 201	343, 570			0. 000000	
	09100 EMERGENCY	2, 391	957, 728				
		309, 289	6, 642, 930			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	625, 764	625, 764	2. 703598	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						101 00
	10100 HOME HEALTH AGENCY	0	0		)		101. 00
	SPECIAL PURPOSE COST CENTERS						11/ 00
	11600 HOSPI CE	0	0				116.00
200.00	Subtotal (see instructions)	11, 950, 878	69, 377, 663	81, 328, 54			200.00
201.00	Less Observation Beds	44 050 555		:	.		201.00
202. 00	Total (see instructions)	11, 950, 878	69, 377, 663	81, 328, 54			202.00

Health Financial Systems	PULASKI MEMORIA	L HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1305	From 10/01/2022	Worksheet C Part I Date/Time Prepared: 2/27/2024 9:32 am

					2/27/2024 9: 32	2 am
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
I NE	PATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDIATRICS					30.00
31. 00   03	100 INTENSIVE CARE UNIT					31.00
43.00 043	300 NURSERY					43.00
ANG	CILLARY SERVICE COST CENTERS					
50.00 050	OOO OPERATING ROOM	0. 000000				50.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 053	300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00 060	000 LABORATORY	0. 000000				60.00
60. 01 060	001 BLOOD LABORATORY	0. 000000				60.01
63.00 063	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06!	500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 066	600 PHYSI CAL THERAPY	0. 000000				66.00
	700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	800 SPEECH PATHOLOGY	0. 000000				68.00
1	900 ELECTROCARDI OLOGY	0. 000000				69.00
	901 CARDIAC REHABILITATION	0. 000000				69. 01
1	000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07:	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07:	300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00   030	020 ONCOLOGY	0. 000000				76.00
OU	TPATIENT SERVICE COST CENTERS	<u>'</u>				
88. 00 088	800 RURAL HEALTH CLINIC	0. 000000				88.00
88. 01 088	801 RURAL HEALTH CLINIC II	0. 000000				88. 01
88. 02 088	802 RURAL HEALTH CLINIC III	0. 000000				88. 02
88. 03 088	803 RURAL HEALTH CLINIC IV	0. 000000				88. 03
	000 CLI NI C	0. 000000				90.00
90. 01   090	001 WOUND CARE	0. 000000				90. 01
91. 00 09	100 EMERGENCY	0. 000000				91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	HER REIMBURSABLE COST CENTERS	<u>'</u>				
101.00 10	100 HOME HEALTH AGENCY				1	101.00
SPI	ECIAL PURPOSE COST CENTERS					
116. 00 110	600 HOSPI CE				1	116.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds				2	201.00
202. 00	Total (see instructions)					202.00

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 10/01/2022 To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		,	r			
50.00 05000 OPERATING ROOM	213, 617		0. 02994		3, 073	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	_	0. 00000		0	52.00
53. 00   05300   ANESTHESI OLOGY	1, 746		0. 00199		19	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	201, 411				2, 047	54.00
60. 00   06000   LABORATORY	83, 201				1, 707	
60. 01   06001   BL00D   LABORATORY	0	_	0. 00000		0	60. 01
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.	2, 824				453	63.00
65. 00   06500   RESPI RATORY THERAPY	34, 847			•	5, 601	65.00
66. 00  06600 PHYSI CAL THERAPY	85, 528	3, 398, 821	0. 02516	49, 657	1, 250	66.00
67. 00  06700 OCCUPATI ONAL THERAPY	4, 020	741, 197			187	67.00
68.00   06800   SPEECH PATHOLOGY	3	0			0	68. 00
69. 00  06900 ELECTROCARDI OLOGY	610	692, 182	0. 00088	1 10, 782	9	69.00
69. 01   06901   CARDI AC   REHABI LI TATI ON	16, 555	380, 137	0. 04355	0	0	69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39, 555	2, 726, 839	0. 01450	6 128, 918	1, 870	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 096	414, 583	0. 01229	2 7, 043	87	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	67, 155	9, 960, 981	0. 00674	2 445, 085	3, 001	73.00
76. 00 03020 ONCOLOGY	23, 073	267, 732	0. 08617	9 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	360, 287	5, 513, 229	0. 06535	0 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	28, 196	589, 883	0. 04779	9 0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	10, 121	100, 633	0. 10057	3 0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	19, 972	622, 744	0. 03207	1 0	0	88. 03
90. 00  09000  CLI NI C	65, 036	343, 570	0. 18929	5 0	0	90.00
90. 01 09001 WOUND CARE	78, 898	960, 119	0. 08217	5 0	0	90. 01
91. 00 09100 EMERGENCY	271, 545	6, 952, 219	0. 03905	9 59, 551	2, 326	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	158, 193	625, 764	0. 25280	0 0	0	92.00
200.00 Total (lines 50 through 199)	1, 771, 489	80, 199, 428		1, 588, 058	21, 630	200. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE OTHER PASS   Provi der CCN: 15-1305	Period: Worksheet D
THROUGH COSTS		From 10/01/2022 Part IV

52. 00   05200   DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ared: am
Anesthetist   Program   Post-Stepdown   Adjustments   Ad	
Cost   Post-Stepdown   Adjustments	
Adjustments   1.00   2A   2.00   3A   3.00	
1.00   2A   2.00   3A   3.00	
ANCI LLARY SERVI CE COST CENTERS  50. 00	
50. 00         05000   0PERATI NG ROOM         0	
52. 00   05200   DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
53. 00   05300   ANESTHESI OLOGY   0   0   0   0	50. 00
	52.00
	53. 00
	54.00
	60.00
	60. 01
	63. 00
	65. 00
	66. 00
	67. 00
	68. 00
	69. 00
	69. 01
	70. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0 0 0 0 0 0	71. 00
	72. 00
	73. 00
	76. 00
OUTPATIENT SERVICE COST CENTERS	
	88. 00
88.01   08801   RURAL HEALTH CLINIC II   0   0   0   0   0	88. 01
88.02   08802   RURAL HEALTH CLINIC   11   0   0   0   0   0   0	88. 02
88.03   08803   RURAL HEALTH CLINIC IV   0   0   0   0   0	88. 03
90. 00   09000  CLI NI C   0   0   0   0   0	90.00
90. 01   09001   WOUND CARE   0   0   0   0   0	90. 01
91. 00   09100   EMERGENCY   0   0   0   0   0	91.00
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0	92.00
200.00   Total (lines 50 through 199)   0   0   0   0	00.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1305		Worksheet D
THROUGH COSTS			From 10/01/2022	Part IV

THROUG	H COSTS				To 09/30/2023		
			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)	cols. 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		1			
50.00	05000 OPERATING ROOM	0	0	(	7, 133, 687	0. 000000	l
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0. 000000	1
53.00	05300 ANESTHESI OLOGY	0	0	(	876, 925	0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	20, 644, 903		
60.00	06000 LABORATORY	0	0	(	15, 993, 763		1
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	145, 337	0. 000000	ı
65.00	06500 RESPI RATORY THERAPY	0	0	(	1, 114, 180		ı
66. 00	06600 PHYSI CAL THERAPY	0	0	(	3, 398, 821	0. 000000	ı
	06700 OCCUPATI ONAL THERAPY	0	0	(	741, 197	0. 000000	
	06800 SPEECH PATHOLOGY	0	0	(	0	0. 000000	ł
	06900 ELECTROCARDI OLOGY	0	0	(	692, 182		
	06901 CARDI AC REHABI LI TATI ON	0	0	(	380, 137	0. 000000	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	2, 726, 839		1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	414, 583		
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	.,	0. 000000	1
76. 00	03020 ONCOLOGY	0	0	(	267, 732	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS	T	T .	1			
	08800 RURAL HEALTH CLINIC	0	1		-,,		
	08801 RURAL HEALTH CLINIC II	0	0	(	589, 883		
	08802 RURAL HEALTH CLINIC III	0	0	(	100, 633		
	08803 RURAL HEALTH CLINIC IV	0	0	(	622, 744		1
90.00	09000 CLI NI C	0	0	(	343, 570		1
90. 01	09001 WOUND CARE	0	0	(	960, 119		1
	09100 EMERGENCY	0	0	(	6, 952, 219		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	020,701		l
200.00	Total (lines 50 through 199)	0	0	(	80, 199, 428	ı	200. 00

Health Financial	Systems		PULA	SKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER PASS	Provi der	From 10/01/2022	Worksheet D Part IV Date/Time Prepared

THROUGH COSTS			Ť.	09/30/2023	Date/Time Pre 2/27/2024 9:3	
		Title	xVIII	Hospi tal	Cost	2 4111
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
· ·	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	J	Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	102, 626	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	9, 644	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	209, 854	0	0	0	54.00
60. 00   06000   LABORATORY	0. 000000	328, 057	0	0	0	60.00
60. 01   06001   BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	23, 315	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	179, 082	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	49, 657		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	34, 444	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	10, 782	0	0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	128, 918	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	7, 043		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	445, 085	1	0	0	73.00
76. 00 03020 ONCOLOGY	0. 000000	0	1	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				- 1		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0. 000000	0	o o	0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0. 000000	0	o o	0	0	88. 02
88. 03   08803 RURAL HEALTH CLINIC IV	0. 000000	0	o o	0	0	88. 03
90. 00 09000 CLI NI C	0. 000000	0	o o	0	0	90.00
90. 01   09001   WOUND CARE	0. 000000	0	o o	0	0	90. 01
91. 00   09100   EMERGENCY	0. 000000	59, 551	l o	ol	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	Ō	o	0	92.00
200.00   Total (lines 50 through 199)		1, 588, 058	· ·	o	-	200. 00

From 10/01/2022 Part V 09/30/2023 Date/Time Prepared: 2/27/2024 9:32 am 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 Ded. & Coins. Part I, col. 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. 303052 1, 562, 275 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.000000 52.00 0 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0.021297 0 201, 752 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 126545 5, 254, 361 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0.156941 4, 427, 285 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0. 481729 45, 393 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.661510 138, 848 0 65.00 06600 PHYSI CAL THERAPY 0.535643 1, 029, 469 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.410405 67.00 107, 955 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.024082 232, 056 0 69.00 69.00 0 0 06901 CARDIAC REHABILITATION 0.425212 167, 740 69.01 69 01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.364061 0 626, 978 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 290400 0 78, 902 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0. 329446 3, 600, 733 2, 031 Ω 73 00 03020 ONCOLOGY 76.00 1. 256951 112, 300 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 1. 535568 180, 560 90.00 90.00 0 09001 WOUND CARE 90.01 0 90.01 0.617373 251, 228 0 Ω 91.00 09100 EMERGENCY 0.670076 0 1, 642, 603 0 0 91.00 92.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2.703598 0 197, 315 0 0 0 200.00 200.00 Subtotal (see instructions) Ω 19, 857, 753 2.031 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

19, 857, 753

2, 031

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	PULASKI MEMORI	AL_HOSPITAL	In Lieu of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1305	Period: Worksheet D From 10/01/2022 Part V To 09/30/2023 Date/Time Prepared:

				From 10/01/2022 To 09/30/2023	Part V Date/Time Pre 2/27/2024 9:3	
		Title	XVIII	Hospi tal	Cost	
<u> </u>	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS		_	1			
50. 00 05000 OPERATING ROOM	473, 451	0	1			50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
53. 00   05300   ANESTHESI OLOGY	4, 297	0	ł			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	664, 913		l .			54.00
60. 00   06000   LABORATORY	694, 823	l e	1			60.00
60. 01 06001 BLOOD LABORATORY	0	1	1			60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	21, 867	0	l .			63.00
65. 00 06500 RESPIRATORY THERAPY	91, 849		1			65.00
66. 00 06600 PHYSI CAL THERAPY	551, 428					66.00
67. 00 06700 OCCUPATIONAL THERAPY	44, 305	ł				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 588	l e				69.00
69. 01   06901   CARDI AC REHABI LI TATI ON 70. 00   07000   ELECTROENCEPHALOGRAPHY	71, 325	0	1			69. 01 70. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	228, 258	1	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 913	l e	1			71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	1, 186, 247					73.00
75. 00 07300 DR0GS CHARGED TO PATTENTS  76. 00 03020 0NC0L0GY	141, 156	ŀ	1			76.00
OUTPATIENT SERVICE COST CENTERS	141, 130	0				70.00
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	277, 262	0				90.00
90. 01   09001   WOUND CARE	155, 101	0				90. 01
91. 00 09100 EMERGENCY	1, 100, 669	O				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	533, 460	l .				92.00
200.00 Subtotal (see instructions)	6, 268, 912	l .				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	6, 268, 912	669				202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	From 10/01/2022	Worksheet D-1 Date/Time Prep 2/27/2024 9:32	
		Title XVIII	Hospi tal	Cost	
Cook Cooker Doored at the					

Deat 1. Li Report Description  1.00    Post 1. Li Report Description   1.00			Title XVIII	Hospi tal	2/21/2024 9: 3 Cost	<u> 2 am </u>
NAME		Cost Center Description		110061 101		
IMPATIENT DAYS   1.00   Inpatient days (including private room days and swing-bed days, excluding nerdorn)   1,947   1.00   Inpatient days (including private room days, accluding swing-bed and newborn days)   1,425   2.00   1.00					1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)   1,477   1,00						
1.25   2.00   Inpatient days (Including private room days, sextualing seing-bed and newborn days)   1.20   2.00   3.00	1. 00		s. excluding newborn)		1. 947	1.00
do not complete this line.  4. 00 Sein-private room days (excluding swing-bed and observation bad days)  Total swing-bad Sit type inpatient days (including private room days) after December 31 of the cost reporting period reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bad New Eye inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bad New Eye inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bad New Eye inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total swing-bad New Eye index of the swing swing-bad and period (if calendar year, enter 0 on this line)  10. 00 Swing-bad SNE type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bad SNE type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bad SNE type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bad SNE 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)  13. 00 Swing-bad NE type inpatient days applicable to title XVIII only (including private room days)  14. 00 Swing-bad NE type inpatient days applicable to title XVIII only (including private room days)  15. 00 New Year (including private room days)  16. 00 Swing-bad NE type inpatient days applicable to services after December 31 of the cost reporting period (including private room days)  17. 00 Madicare rate for swing-bad SNE services applicable to services through December 31 of the cost reporting period (inc					•	1
Semi-perivate room days (excluding swing-bed and observation bed days)   Semi-perivate room days (including private room days) through December 31 of the cost reporting period   Total swing-bed Str type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31	3.00		ys). If you have only pr	ivate room days,	0	3.00
Total 'swing-bed SNF 'type inpatient days' (including private room days) after December 31 of the cost reporting period (if cell endar year, enter 0 on this line)  7.00 Total 'swing-bed NF 'type inpatient days' (including private room days) after December 31 of the cost reporting period (if cell endar year, enter 0 on this line)  7.00 Total 'swing-bed NF 'type inpatient days' (including private room days) after December 31 of the cost reporting period (if cell endar year, enter 0 on this line)  9.00 Total 'inpatient days' including private room days) after December 31 of the cost reporting period (if cell endar year, enter 0 on this line)  10.00 Swing-bed NF 'type inpatient days' (including private room days) after December 31 of the cost reporting period (if cell endar year, enter 0 on this line)  11.00 Swing-bed NF 'type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cell endar year, enter 0 on this line)  12.00 Swing-bed NF 'type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cell endar year, enter 0 on this line)  13.00 Swing-bed NF 'type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Total 'inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total 'inpatient days applicable to titles V or XIX only (including private room days)  16.00 Narsery days (title V or XIX only)  17.00 Medicar period (if cell endar year, enter 0 on this line)  18.00 Medicar rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (including private room days)  18.00 Medicar rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (including period (including private room days)  18.00 Medicar rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period (inc	4 00	·			004	4 00
reporting period ("First Period of Start Perio				or 31 of the cost		•
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Response of days (see instructions) water room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) are 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) 11.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIX only (including private room days) 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 title SV or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 North of the period of the period (if calendar year, enter 0 on this line) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost period of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost period of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost period (line of x x line x) 19.00 Medicare rate for swing-bed SNF services after December 31 of the cost reporting period (line of x x line x) 19.00 Medicare rate for swing-bed SNF ser	3.00		om days) trii odgir becembe	i or the cost	147	3.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and step 1 on the cost reporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days applicable to title XVII only (including private room days)   147   10.00   Swing-bed SNF type inpatient days applicable to title XVII only (including private room days)   148   10.00   Swing-bed SNF type inpatient days applicable to title XVII only (including private room days)   12.00   Swing-bed NF type inpatient days applicable to title XVII only (including private room days)   12.00   Swing-bed NF type inpatient days applicable to title XVII only (including private room days)   12.00   Swing-bed NF type inpatient days applicable to title XVII only (including private room days)   12.00   Swing-bed NF type inpatient days applicable to title XVII only (including private room days)   13.00   13.00   Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)   14.00   15.0	6.00		om days) after December	31 of the cost	206	6.00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions)  10. 00 Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) after 0 December 31 of the cost (including private room days) af	7.00		and the second second	24 . 6 . 1	45	7.00
7 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8 Ming-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9 Total properties of the cost reporting period (see instructions) 9 Total properties of the cost reporting period (see instructions) 9 Total properties of the cost reporting period (see instructions) 9 Total properties of the cost reporting period (see instructions) 1 Total properties of the cost reporting period (see instructions) 1 Total properties of the cost reporting period (see instructions) 1 Total properties of the cost reporting period (if calendar year, enter 0 on this line) 1 Total nursery days (title V or XIX only) 1 Total nursery days (title V or XIX only) 1 Total nursery days (title V or XIX only) 1 Total nursery days (title V or XIX only) 1 Total nursery days (title V or XIX only) 2 Total nursery days (title V or XIX only) 3 Total nursery days (title V or XIX only) 3 Total nursery days (title V or XIX only) 4 Total nursery days (title V or XIX only) 5 Total nursery days (title V or XIX only) 5 Total nursery days (title V or XIX only) 6 Total nursery days (title V or XIX only) 7 Total deciral or active of swing-bed SNF services applicable to services after December 31 of the cost reporting period (see instructions) 8 Total general inpatient routine service cost (see instructions) 9 Total general inpatient routine services applicable to services after December 31 of the cost reporting period (line S X I ine 17) 1 Total general inpatient routine service cost (see instructions) 1 Total general inpatient routine service cost (see instructions) 2 Total general inpatient routine service cost (see instructions) 2 Total general inpatient routine service cost from the cost reporting period (line S X I ine 17) 2 Total gener	7.00		m days) through becember	31 of the cost	15	7.00
reporting period (if calendar year, enter 0 on this line)  10. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SMF type inpatient days applicable (see instructions)  12. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after observed through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  16. 00 Nursery days (title V or XIX only)  17. 00 Swing-bed Swing-b	8. 00		m days) after December 3	1 of the cost	154	8.00
newborn days) (see instructions)   147   10.00   10.		reporting period (if calendar year, enter 0 on this line)	-			
1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 2.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 2.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 3.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 3.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 3.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 3.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 3.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 3.01 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 3.01 Swing-bed SNF type (title V or XIX only) 3.02 SNF	9. 00		o the Program (excluding	swing-bed and	345	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SMF type inpatient days applicable to titlex Vor XIX only (including private room days) after 206 11.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical IV necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days)  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line size applicable to SNF type services through December 31 of the cost reporting period (line size applicable to SNF type services after December 31 of the cost reporting period (line size applicable to SNF type services after December 31 of the cost reporting period (line size applicable to SNF type services after December 31 of the cost reporting period (line size applicable to SNF type services after December 31 of the cost reporting period (line size applicable to SNF type services after December 31 of the	10 00		nlv (including private r	room days)	147	10 00
December 31 of the cost reporting period (If calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)  14.00 Medical I/I necember 31 of the cost reporting period (If calendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (Including private room days applicable to services after December 31 of the cost reporting period (Including private room days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (Including private room days)  19.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (Including private room days)  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including p				com dayo)		10.00
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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)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nessery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.01 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of x line 17)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 19)  26.00 Total swing-bed cost see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  28.00 Alverage seri-private room per diem charge (line 39 + line 3)  29.00 Office and inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  39.00 Average per diem private room cost differe	12 00			o room days)	_	12 00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including privater room days)   13.00   13.00   14.00   14.00   14.00   15.00	12.00		A only (including privat	e room days)		12.00
14.00   Modically necessary private room 'days applicable' to the Program (excluding swing-bed days)   0   14.00   0   15.00	13.00		X only (including privat	e room days)	0	13.00
15.00   Total nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   16.00   17.00   SWING BED ADJUSTMENT   17.00   18.00   SWING BED ADJUSTMENT   17.00   18.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18.00   19.00   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 after December 31 of the cost   250.44   19.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost   266.32   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost   266.32   20.00   Total general inpatient routine service cost (see instructions)   4.865.361   21.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   2.20.00   22.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   3.757   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   3.757   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   3.757   26.00   Total swing-bed cost (see Instructions)   1.001,838   27.00   Swing-bed cost (see Instructions)   1.001,838   28.00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3.863,523   27.00   Private room charges (excluding swing-bed charges)   0.200   28.00   Overage private room charges (excluding swing-bed charges)   0.200   29.00   Private room charges (excluding swing-bed charges)   0.200   29.00   Overage private room period mental adjustment (line 3 × line 4)   0.00   29.00   Overage period mental period mental (line 3 × line 35)   0.00   29.00   Average period mental period mental (line 3 × line 35)   0.00   29.00   Average period mental					_	
16.00 Nursery days (title V or XIX only)  SWING BED ADJUSTIENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period of swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of x in line 18)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x in line 18)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x in line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x in line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x in line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  20.00 Severage private room charges (excluding swing-bed charges)  20.00 Of General inpatient routine service cost (line 27 ± line 28)  20.00 Of General inpatient routine service cost reporting period (line 27 ± line 28)  20.00 Of General inpatient routine service cost period (line 27 ± line 28)  20.00 Of General in			am (excluding swing-bed	days)		
SWING BED ADJUSTMENT   17.00   17.00   18.00   17.00   18.00   18.00   18.00   18.00   19.00						
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 250. 44 19.00  reporting period (20.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 266. 32 20.00  reporting period (20.00)  Total general inpatient routine service cost (see instructions) (20.00)  All sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (11 ne 5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11 ne 5 x line 18)  All sing-bed cost applicable to NF type services through December 31 of the cost reporting period (11 ne 7 x 15 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 7 x 15 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 8 x 11 ne 18)  Mang-bed cost applicable to NF type services after December 31						
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 250.44 19.00 medical drate for swing-bed NF services applicable to services after December 31 of the cost 266.32 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 4,865,361 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 Swing-bed cost (see instructions) 1,001.838 26.00 Total swing-bed cost (see instructions) 1,001.838 26.00 27.00 PRIVATE ROWD INFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 0,29.00 20.00 Private room charges (excluding swing-bed charges) 0,29.00 20.00 Private room charges (excluding swing-bed charges) 0,29.00 20.00	17. 00	11	es through December 31 c	of the cost		17. 00
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19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   4,865,361   21.00   Total general inpatient routine service cost (see instructions)   4,865,361   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line   5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   6 x line 18)   23.00   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   7 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   8 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   8 x line 20)   26.00   Total swing-bed cost (see instructions)   1,001,838   26.00   27.00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3,863,523   27.00   28.00   Private room charges (excluding swing-bed charges)   0 29.00   29.00   Private room charges (excluding swing-bed charges)   0 29.00   2	10.00	, , ,	es al tel becember 51 01	the cost		10.00
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reporting period Total general inpatient routine service cost (see instructions)  22.00  23.00  33.00  34,865,361  21.00  22.00  35 x line 17)  24.00  25 x line 18)  25 wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  26 x line 18)  27 wine 19)  28 wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 18)  28 wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 19)  29 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  20 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  20 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  21 wine 20)  22 wing-bed cost (see instructions)  23 wing-bed cost (see instructions)  24 wine 20)  25 wing-bed cost (see instructions)  26 wing-bed cost (see instructions)  27 wine 20)  28 wing-bed cost (see instructions)  28 wing-bed cost (see instructions)  29 wing-bed cost (see instructions)  29 wing-bed cost (see instructions)  30 wing-bed cost (see instructions)  30 wing-bed cost (see instructions)  31 wine 20)  32 wing-bed cost (see instructions)  32 wing-bed cost (see instructions)  33 wing-bed cost (see instructions)  34 wine 20)  35 wing-bed cost (see instructions)  36 wing-bed cost (see instructions)  37 wine 20)  38 wing-bed cost (see instructions)  38 wing-bed cost (see instructions)  39 wing-bed cost (see instructions)  40 wine 20  41 wine 20  42 wine 20  43 wing-bed cost (see instructions)  44 wine 20  45 wine 20  47 wine 20  48 wine 20  49 wine 20  40 wine 20  40 wine 20  40 wine 20  41 wine 20  42 wine 20  43 wine 20  44 wine 20  45 wine 20  46 wine 20  47 wine 20  48 wine 20  49 wine 20  40 wine 20	20.00		o often December 21 of t	ho oost	244 22	20.00
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  4.00 Average private room per diem charge (line 29 + line 3)  31.00 Average private room per diem charge (line 29 + line 3)  32.00 Average per diem private room per diem charge (line 30 + line 4)  33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 32 minus line 33)  35.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  48.00 Program general inpatient routine service cost (line 9 x line 38)  48.00 Wedically necessary private room cost applicable to the Program (line 14 x line 35)  48.00 Wedically necessary private room cost applicable to the Program (line 14 x line 35)  48.00 Wedically necessary private room cost applicable to the Program (line 14 x line 35)	20.00		s arter becember 31 or t	ne cost	200. 32	20.00
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 3,757 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service charges ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 29 + line 3)  34.00 Average per diem private room charge differential (line 30 + line 4)  34.00 Average per diem private room cost differential (line 31 minus line 33) (see instructions)  37.00 General inpatient routine service cost per diem (line 30 + line 31)  38.00 Average per diem private room cost differential (line 34 x line 31)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost of applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21. 00	Total general inpatient routine service cost (see instruction				21.00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 * line 3)  30.00 Semi-private room per diem charge (line 29 * line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential dipustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 35 x line 35)  30.00 Average per diem private room cost differential (line 35 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 38 x line 35)  30.00 Av	22. 00		er 31 of the cost report	ing period (line	0	22. 00
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 3, 757 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 41, 013 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 1,001,838 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,863,523 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.00000 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.00000 31.00 32.00 Average private room per diem charge (line 29 + line 3) 0.00 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Provate room cost differential adjustment (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average line and the provate room cost differential (line 3 x line 35) 0.00 Average line and the provate room cost differential (line 3 x line 35) 0.00 Average line and the provate room cost differential (line 3 x line 35) 0.00 Average line and the provate room cost differential (line 3 x line 35) 0.00 Average line and the provate room cost differential (line 3 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	23 00	· · · · · · · · · · · · · · · · · · ·	31 of the cost reportin	ng neriod (line A	0	23 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 41,013 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		or the cost reportin	ig period (iiile d		25.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 29 + line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  37.00 Private room cost differential service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		r 31 of the cost reporti	ng period (line	3, 757	24. 00
x line 20)  26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Private room charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 * line 28)  32.00 Average private room per diem charge (line 29 * line 3)  33.00 Average semi-private room per diem charge (line 30 * line 4)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25 00	/	21 -6		41 012	25 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  RI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Frivate room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  37.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost differential (line 3, 863, 523)  30.00 Average per diem private room cost dif	25.00		31 of the cost reporting	period (line 8	41,013	25.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average pri vate room per diem charge (line 29 + line 3)  32. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  33. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  34. 00 Average per diem pri vate room cost differential (line 34 x line 31)  35. 00 Average per diem pri vate room cost differential (line 3 x line 35)  36. 00 Pri vate room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 3, 863, 523)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Program general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  935. 375. 376. 3876. 399. 00  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  28. 00  29. 00  20. 00  30. 00  30. 00  30. 00  31. 00  32. 00  32. 00  33. 00  34. 00  35. 00  36. 00  37. 00  37. 00  38. 00  38. 00  39. 00  39. 00  40. 00	26. 00				1, 001, 838	26.00
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00 Average private room per diem charge (line 29 ÷ line 3)  30. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  31. 00 Average per diem private room cost differential (line 3 x line 35)  32. 00 Average per diem private room cost differential (line 3 x line 35)  33. 00 Average per diem private room cost differential (line 3 x line 35)  34. 00 Average per diem private room cost differential (line 3 x line 35)  35. 00 Average per diem private room cost differential (line 3 x line 35)  36. 00 Average per diem private room cost differential (line 3 x line 35)  37. 00 Average per diem private room cost differential (line 3 x line 35)  38. 00 Average per diem private room cost differential (line 3 x line 35)  39. 00 Average per diem private room cost differential (line 3 x line 35)  39. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 A	27. 00		(line 21 minus line 26)		3, 863, 523	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523) 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 29.00 30.00 30.00 30.00 31.00 32.00 32.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00	20 00		d and observation had ch	arace)	0	20 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			d and observation bed cr	iai yes)		
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	÷ line 28)			1
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00 35.00 36.00 37.00 36						1
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 863, 523)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nuc lino 22) (coo inct	eti onc)		1
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,711.24 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 40.00		,	iie 31 <i>)</i>			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,711.24 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,	and private room cost di	fferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,711.24 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		27 minus line 36)		•		
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,711.24 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  2,711.24 38.00 935,378 39.00			LICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 935,378 39.00 40.00	38 00				2 711 24	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , , , , , , , , , , , , , , , , , , ,	•			1
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 935,378   41.00	40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		935, 378	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	PULASKI MEMORIA		CCN: 15-1305	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 10/01/2022 To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
				e XVIII	Hospi tal	Cost	7 <u>2</u> um
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per		Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)	'	col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	0		0. 0	00 0	0	42.
2 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		ol 0. 0	ool ol	0	142
3. 00 4. 00	CORONARY CARE UNIT	٥		0.0	0	l	43. 44.
5. 00	BURN INTENSIVE CARE UNIT						45.
o. 00	SURGICAL INTENSIVE CARE UNIT						46.
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 515, 553	48
3. 01	Program inpatient cellular therapy acquisiti	on cost (Workshe	et D-6, Par	t III, line 10	), column 1)	0	1
9. 00	Total Program inpatient costs (sum of lines	41 through 48.01	)(see instr	uctions)	,	1, 450, 931	49.
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inp	atient routine s	ervices (fr	om Wkst. D, su	ım of Parts I and	0	50.
. 00	<pre>                                    </pre>	ationt ancillary	sarvicas (	from Wkst D	sum of Darts II	0	51.
. 00	and IV)	attent anertrary	SCI VICCS (	Tolli WKSt. D,	Sum of Full 13 11	I	31
. 00	Total Program excludable cost (sum of lines					0	1
8. 00	Total Program inpatient operating cost exclu		ated, non-pl	nysician anest	hetist, and	0	53
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor	use only)				0.00	55
. 00	Target amount (line 54 x sum of lines 55, 55					0	1
. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount	(line 56 minus	; line 53)	0	
. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost re	porting porior	londing 1006	0.00	
. 00	updated and compounded by the market basket)		the cost rep	Joi tring period	ending 1990,	0.00	39
0. 00	Expected costs (lesser of line 53 ÷ line 54,		pri or year	cost report,	updated by the	0.00	60
	market basket)						
1.00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by	which operati	ng costs (line	0	61.
2. 00	Relief payment (see instructions)					0	62
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST					200 550	١
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of ti	ne cost report	ing period (See	398, 552	64
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the	cost reportir	na period (See	558, 515	65
	instructions)(title XVIII only)				9		
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line	65)(title XVI	<pre>II only); for</pre>	957, 067	66
	CAH, see instructions		D	6 11			, ,
7.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	or the cost r	eporting period	0	67
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 o	f the cost rer	orting period	0	68
	(line 13 x line 20)			·	5 1 2 2 2		
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N				()		70
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				,		71
. 00	Program routine service cost (line 9 x line			,			72
. 00	Medically necessary private room cost applic		(line 14 x	ine 35)			73
. 00	Total Program general inpatient routine serv				_		74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksheet B,	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu	s line 77)					78
. 00	Aggregate charges to beneficiaries for exces						79
. 00	Total Program routine service costs for comp		st limitatio	on (line 78 mi	nus line 79)		80
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81
. 00	Reasonable inpatient routine service costs (	,	)				83
. 00	Program inpatient ancillary services (see in		,				84
. 00	Utilization review - physician compensation		s)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 thr	ouah 85)				86
. 00							1
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	g,			624	07

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 10/01/2022 To 09/30/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			1, 691, 814	89. 00
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	454, 938	4, 865, 361	0. 09350	1, 691, 814	158, 193	90.00
91.00 Nursing Program cost	0	4, 865, 361	0. 00000	1, 691, 814	0	91.00
92.00 Allied health cost	0	4, 865, 361	0. 00000	00 1, 691, 814	0	92.00
93.00 All other Medical Education	0	4, 865, 361	0. 00000	00 1, 691, 814	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 10/01/2022	Worksheet D-1	
				Date/Time Pre 2/27/2024 9:3	pared: 2 am
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	

		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			1, 947	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 425	
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation b	ed days)		801	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	125	
	reporting period	3 / 3			
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	228	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	m daya) +brayab Dagambar	21 of the cost	15	7 00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	ili days) tili odgir becellber	31 Of the Cost	15	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	154	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	6	9. 00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		days)	· ·	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11. 00
40.05	December 31 of the cost reporting period (if calendar year, e			_	40.05
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lin	e)	Ü	10.00
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	if the cost		17. 00
17.00	reporting period	es im ough becomber or e	T the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
40.00	reporting period		5 116	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.00
	reporting period				
21.00				4, 865, 361	
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 00
	x line 18)		]		
24. 00	] 3 11 31	r 31 of the cost reporti	ng period (line	0	24. 00
25 00	7 x line 19)	21 of the cost reporting	noried (line O	0	25. 00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	perrou (Trie 8	U	25.00
26.00				965, 956	26. 00
27. 00		(line 21 minus line 26)		3, 899, 405	
20. 22	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	d and abana (17 ) ( 1 ) (			00.00
28.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	arges)	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	
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)		11	0.00	1
34.00	Average per diem private room charge differential (line 32 mi		TI ONS)	0.00	1
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 899, 405	
	27 minus line 36)	,			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			2 727 42	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 736. 42 16, 419	1
40.00				10, 419	1
	Total Program general inpatient routine service cost (line 39				41.00
		•	'	•	

COMPUTATION OF INPATIENT OPERATING COST		Provider C	CCN: 15-1305	Peri od:	u of Form CMS-2 Worksheet D-1		
				From 10/01/2022 To 09/30/2023	Date/Time Pre		
		Ti ti	le XIX	Hospi tal	2/27/2024 9: 3 Cost	2 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1.00	2. 00	3.00	4.00	5. 00 0	42.00	
43.00 Intensive Care Type Inpatient Hospital Unit	s 0	(	0.0	00 0	0	43.00	
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)			0.0	0	0	44. 00 45. 00 46. 00 47. 00	
Cost Center Description					1. 00		
48.00 Program inpatient ancillary service cost (V 48.01 Program inpatient cellular therapy acquisit 49.00 PASS THROUGH COST ADJUSTMENTS	ion cost (Works	heet D-6, Part		, column 1)	15, 062 0 31, 481	48. 01	
50.00 Pass through costs applicable to Program in	npatient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.00	
51.00 Pass through costs applicable to Program in	npatient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00	
and IV) 52.00 Total Program excludable cost (sum of lines					0		
53.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		erated, non-ph	ıysıcıan anest	netist, and	0	53.00	
54. 00 Program di scharges					0		
55.00 Target amount per discharge 55.01 Permanent adjustment amount per discharge					0. 00 0. 00		
55.02 Adjustment amount per discharge (contractor	<b>J</b> ,				0.00	55. 02	
56.00 Target amount (line 54 x sum of lines 55, 57.00 Difference between adjusted inpatient operations)		•	ling 56 minus	line 53)	0		
58.00 Bonus payment (see instructions)	iting cost and t	arget amount (	Title 50 millius	111le 53)	0	58.00	
59.00 Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket		0. 00	59. 00				
60.00 Expected costs (lesser of line 53 ÷ line 54 market basket)		0. 00	60.00				
61.00 Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)	esser of 50% of	the amount by	which operati	ng costs (line	0	61.00	
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive pay	yment (see instr	uctions)			0		
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine co	osts through Dec	ember 31 of th	ne cost report	ing period (See	0	64.00	
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine co	osts after Decem	ber 31 of the	cost reportin	g period (See	0	65.00	
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	II only); for	0	66.00	
CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routi	ne costs throug	h December 31	of the cost r	eporting period	0	67. 00	
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routi	_				0	68. 00	
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lir	ne 68)	0.1	0	69. 00	
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing faci	NURSING FACILIT	Y, AND ICF/IID	ONLY	)		70.00	
71.00 Adjusted general inpatient routine service				,		71.00	
72.00 Program routine service cost (line 9 x line						72.00	
73.00   Medically necessary private room cost appli 74.00   Total Program general inpatient routine ser		•				73.00	
		ce costs (IIne /2 + IIne /3) outine service costs (from Worksheet B, Part II, column					
76.00 Per diem capital-related costs (line 75 ÷ l						76.00	
77.00 Program capital-related costs (line 9 x lir 78.00 Inpatient routine service cost (line 74 mir						77. 00 78. 00	
78.00 Inpatient routine service cost (line 74 mir 79.00 Aggregate charges to beneficiaries for exce		provi der recor	ds)			79.00	
80.00 Total Program routine service costs for com				nus line 79)		80.00	
81.00 Inpatient routine service cost per diem lim		4.)				81.00	
82.00   Inpatient routine service cost limitation (83.00   Reasonable inpatient routine service costs						82.00	
84.00 Program inpatient ancillary services (see i		113)				84.00	
85.00 Utilization review - physician compensation	n (see instructi					85.00	
86. 00 Total Program inpatient operating costs (su		hrough 85)				86.00	
PART IV - COMPUTATION OF OBSERVATION BED PA 87.00 Total observation bed days (see instruction					624	87. 00	
	- /				2, 736. 42	1	

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-1305	Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			1, 707, 526	89.00
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	454, 938	4, 865, 361	0. 09350	1, 707, 526	159, 662	90.00
91.00 Nursing Program cost	0	4, 865, 361	0. 00000	1, 707, 526	0	91.00
92.00 Allied health cost	0	4, 865, 361	0. 00000	0 1, 707, 526	0	92.00
93.00 All other Medical Education	0	4, 865, 361	0. 00000	0 1, 707, 526	0	93.00

	Financial Systems PULASKI MEMORIA ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od:	u of Form CMS-: Worksheet D-3	
				From 10/01/2022		
				To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDI ATRI CS			408, 668		30.00
	03100 I NTENSI VE CARE UNI T			0		31.00
43. 00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 3030		31, 101	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
	05300 ANESTHESI OLOGY		0. 0212		205	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1265	· ·	26, 556	1
0.00	06000 LABORATORY		0. 1569		51, 486	1
50. 01 53. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000 0. 4817		0 11, 232	60.0
55.00	06500 RESPIRATORY THERAPY		0. 4617		118, 465	
6. 00	06600 PHYSI CAL THERAPY		0.5356		26, 598	
7. 00	06700 OCCUPATI ONAL THERAPY		0. 41040		14, 136	
8.00	06800 SPEECH PATHOLOGY		0. 00000		0	
9.00	06900 ELECTROCARDI OLOGY		0. 0240		260	
9. 01	06901 CARDI AC REHABI LI TATI ON		0. 4252	12 0	0	69.0
0.00	07000 ELECTROENCEPHALOGRAPHY		0.0000	00	0	70.0
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3640		46, 934	
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 29040		2, 045	
	07300 DRUGS CHARGED TO PATIENTS		0. 3294	· ·	146, 631	
6. 00	03020 ONCOLOGY		1. 2569	51 0	0	76.0
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC		0.0000	00	0	88.0
	08801 RURAL HEALTH CLINIC II		0.0000		0	
88. 02	08802 RURAL HEALTH CLINIC III		0.0000		0	88. 0
8. 03	08803 RURAL HEALTH CLINIC IV		0.0000		0	1
	09000 CLINIC		1. 5355		0	90.0
0. 01	09001 WOUND CARE		0. 6173		0	
1.00	09100 EMERGENCY		0. 6700		39, 904	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 7035	· ·	0	92.0
200.00				1, 588, 058	515, 553	200.0
201.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.0
202.00	Net charges (line 200 minus line 201)		1	1, 588, 058		202.0

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1305		i od:	Worksheet D-3	3
		Component	CCN: 15-Z305	Fro To	om 10/01/2022 09/30/2023	Date/Time Pre 2/27/2024 9:3	
		Title	xVIII	Swi	ng Beds - SNF		, <u>, , , , , , , , , , , , , , , , , , ,</u>
Cost Center Description			Ratio of Cos		I npati ent	I npati ent	
			To Charges	5	Program	Program Costs	
					Charges	(col . 1 x	
			1.00		2. 00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS							30.00
31. 00   03100   NTENSI VE CARE UNI T							31.00
43. 00   04300   NURSERY							43.00
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM			0. 3030	52	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.0000	000	0	0	52.00
53. 00   05300   ANESTHESI OLOGY			0. 0212	97	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1265	45	32, 619	4, 128	54.00
60. 00   06000   LABORATORY			0. 1569	41	73, 521	11, 538	
60. 01   06001   BL00D   LABORATORY			0.0000		0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 4817	29	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY			0. 6615		19, 559	12, 938	1
66. 00   06600   PHYSI CAL THERAPY			0. 5356		130, 296	69, 792	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 4104		61, 187	25, 111	
68. 00 06800 SPEECH PATHOLOGY			0.0000		0	0	
69. 00 06900 ELECTROCARDI OLOGY			0. 0240		1, 609	39	
69. 01 06901 CARDI AC REHABI LI TATI ON			0. 4252		0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY			0.0000		0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 3640		42, 837	15, 595	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 2904		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 3294		83, 394	27, 474	
76. 00 O3020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS			1. 2569	51	0	0	76.00
88. 00 08800 RURAL HEALTH CLINIC			0.0000	000		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 CLINIC IV			0.0000			0	
90. 00   09000   CLINIC			1. 5355		0	0	
90. 01   09001   WOUND CARE			0. 6173		0	0	1
91. 00   09100   EMERGENCY			0. 6700		14, 597	9, 781	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			2. 7035		, 0,,	,,,,,,	1
200.00 Total (sum of lines 50 through 94 and	96 through 98)		2.7000		459, 619	_	
201.00 Less PBP Clinic Laboratory Services-Pr		s (line 61)	[		0	1.2,070	201.00
202.00 Net charges (line 200 minus line 201)	5	/	1		459, 619		202.00

Health Financial Systems	PULASKI MEMORIAL HOSPITA			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	er CCN: 15-1305	Peri od:	Worksheet D-3	1
			From 10/01/202 To 09/30/202		pared: 2 am
		Title XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Co		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_	
30. 00   03000   ADULTS & PEDI ATRI CS			5, 34	1	30.00
31. 00   03100   INTENSIVE CARE UNIT				0	31.00
43. 00   04300   NURSERY				0	43.00
ANCILLARY SERVICE COST CENTERS		0.000	5.04	1 500	
50. 00 05000 OPERATING ROOM		0. 3030			1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
53. 00 05300 ANESTHESI OLOGY		0. 0212			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1265			
60. 00   06000   LABORATORY		0. 1569			
60. 01 06001 BLOOD LABORATORY		0.0000		0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 481		0	
65. 00   06500   RESPI RATORY THERAPY		0. 6615		•	65.00
66. 00   06600   PHYSI CAL THERAPY		0. 5356		•	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4104		1	1
68. 00 06800 SPEECH PATHOLOGY		0.0000		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 0240		l	1
69. 01   06901   CARDI AC   REHABI LI TATI ON		0. 4252		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0 0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 3640			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2904		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3294			1
76. 00   03020   0NCOLOGY		1. 2569	951	0 0	76.00
OUTPATIENT SERVICE COST CENTERS		4 547/	207		00.00
88. 00 08800 RURAL HEALTH CLINIC		1. 5172		0	
88. 01   08801 RURAL HEALTH CLINIC II		2. 3523		0	
88. 02 08802 RURAL HEALTH CLINIC III		4. 4006		0	
88. 03 08803 RURAL HEALTH CLINIC IV		1. 817		0	
90. 00   09000   CLI NI C		1. 5355		0	90.00
90. 01   09001   WOUND CARE		0. 6173		0	
91. 00 09100 EMERGENCY		0. 6700			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	04 +brough 00)	2. 7035		0	
Total (sum of lines 50 through 94 and		(1)	52, 13	15, 062	
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (Tine	01)	E0 10	J =	201.00
202.00 Net charges (line 200 minus line 201)		I	52, 13	ol .	202.00

Week the Fire and a Contain	COL MEMORIAL HOCKLEAL		1-11-	£ F CMC /	2552 40
Health Financial Systems PULA INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ASKI MEMORIAL HOSPITAL Provider C	CN: 15-1305	Period:	u of Form CMS-2 Worksheet D-3	
		CCN: 15-Z305	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/27/2024 9:3	pared:
	Ti tl	e XIX	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00   03100   NTENSI VE CARE UNI T					31.00
43. 00   04300   NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		•			45.00
50. 00 05000 OPERATING ROOM		0.0000	00 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000			
53. 00   05300   ANESTHESI OLOGY		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.00000		0	54.00
60. 00   06000   LABORATORY		0.00000	00	0	60.00
60. 01   06001   BLOOD LABORATORY		0.0000	00	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
65. 00 06500 RESPI RATORY THERAPY		0.00000		0	
66. 00   06600   PHYSI CAL THERAPY		0.00000		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
68. 00 06800 SPEECH PATHOLOGY		0.0000		0	
69. 00   06900   ELECTROCARDI OLOGY		0.00000		0	
69. 01   06901   CARDI AC   REHABI LI TATI ON		0.00000		0	
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 00000 0. 00000		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.0000		0	
76. 00 03020 ONCOLOGY		0.00000		-	
OUTPATIENT SERVICE COST CENTERS		0.0000	50  0		70.00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00 00	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	88. 01
88.02 08802 RURAL HEALTH CLINIC III		0.00000	00 0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV		0.00000	00	0	88. 03
90. 00   09000   CLI NI C		0.00000	00	0	90.00
90. 01   09001   WOUND CARE		0.00000		0	
91. 00   09100   EMERGENCY		0.00000		0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0.00000		0	
200.00 Total (sum of lines 50 through 94 and 96 th			0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	0		202.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1305	Peri od: From 10/01/2022 Part B To 09/30/2023 Date/Ti me Prepared: 2/27/2024 9: 32 am

		Title XVIII	Hospi tal	2/21/2024 9: 3 Cost	2 am
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			6, 269, 581	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		0	2.00
3. 00 4. 00	OPPS or REH payments			0	3. 00 4. 00
4. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00
5. 00	Enter the hospital specific payment to cost ratio (see instructi	ions)		0.000	5. 00
6. 00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 269, 581	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 207, 301	11.00
	Reasonable charges				
12.00	Ancillary service charges			0	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pay	ument for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for p	•	0	0	16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	odyment for services e	ii a chargebasi s		10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	no 10) (coo	0	20. 00
20.00	instructions)	II IIIIe II exceeus II	116 10) (366	U	20.00
21. 00	Lesser of cost or charges (see instructions)			6, 332, 277	21. 00
22.00	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			44 275	25. 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 2	24 (for CAH see instr	uctions)	64, 275 3, 104, 129	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu			3, 163, 873	
	instructions)		, (	5, 122, 212	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
	REH facility payment amount				28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			3, 163, 873 6, 262	1
	Subtotal (line 30 minus line 31)			3, 157, 611	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		57.15.75.1	
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			393, 216	
	Adjusted reimbursable bad debts (see instructions)	-+:>		255, 590	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ctions)		201, 474 3, 413, 201	
	MSP-LCC reconciliation amount from PS&R			3, 413, 201	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	tions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION			2 412 201	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 413, 201 68, 264	40. 00 40. 01
40. 01	Demonstration payment adjustment amount after sequestration			00, 204	40. 01
	Sequestration adjustment-PARHM pass-throughs			· ·	40. 03
	Interim payments			3, 826, 834	41.00
41. 01	Interim payments-PARHM				41. 01
42.00	· · · · · · · · · · · · · · · · · · ·			0	
42. 01	Tentative settlement-PARHM (for contractor use only)			401 007	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-481, 897	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	chapter 1	0	1
55	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)			0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)				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		Worksheet E	
				From 10/01/2022		
				To 09/30/2023		
					2/27/2024 9:	32 am
			Title XVIII	Hospi tal	Cost	
					1. 00	
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days						0 200. 00

| Peri od: | Worksheet E-1 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: Provi der CCN: 15-1305

Title XVIII   Hospital   Cost					10 09/30/2023	2/27/2024 9: 3	
March   Marc			Title	XVIII	Hospi tal		
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   3.159,302			Inpatien	nt Part A	Par	rt B	
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   1.159,302   3.756,234   3.159,302		- r	mm /dd /\\\\\	Amount	mm/dd/\\\\\\	Amount	
10   10   10   10   10   10   10   10		<u> </u>					
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	00 Total interim payments paid to provider		1.00				1.00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				1, 107, 00			2. 00
SerVices rendered in the cost reporting period. If none, write "NONE" or enter a zero write "NONE" or enter a zero to test separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							2.00
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider		ne,					
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   ADJUSTMENTS TO PROVIDER   0 0/24/2023   70,600   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   3.   0 0 0 0   0 0 0   3.   0 0 0 0   0 0   0 0							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	.00 List separately each retroactive lump sum adjustment						3.00
payment   If none, write "NONE" or enter a zero. (1)   Program to Provider   ADJUSTMENTS TO PROVIDER   0   0   1/24/2023   70, 600   3.   0   0   0.   3.   0.   0   0.   3.   0.   0		)					
Program to Provider							
ADJUSTMENTS TO PROVIDER							
0							
0							3. 01
ADJUSTMENTS TO PROGRAM							3. 02
Dock							3. 03
Provider to Program							3. 04
ADJUSTMENTS TO PROGRAM					0	0	3. 05
1.52				1	_1	_	
S2					-		3. 50
Sab					-	1	
Solution				-	1	3. 52	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					-		
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   1,159,302   3.826,834   4.1   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR					-	1	
Total interim payments (sum of lines 1, 2, and 3.99)					U	70, 600	3. 99
Contractor   Con				1 150 20	12	2 026 024	4. 00
Appropriate   In BE COMPLETED BY CONTRACTOR   Ist separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider				1, 157, 30	,2	3, 620, 634	4.00
TO BE COMPLETED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider				1			
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider		-					5. 00
Write "NONE" or enter a zero. (1)   Program to Provider							
TENTATI VE TO PROVIDER	write "NONE" or enter a zero. (1)						
Description	Program to Provider						
Description	. 01 TENTATI VE TO PROVI DER				0	0	5.01
Provider to Program	. 02				0	0	5. 02
TENTATI VE TO PROGRAM	. 03				0	0	5.03
0							
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50-5.98)   Subtotal (sum of lines 6.5							5. 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)							5. 51
5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) 1.01 SETTLEMENT TO PROVIDER 1.02 SETTLEMENT TO PROGRAM 1.00 Total Medicare program liability (see instructions) 1.327,938 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						1	5. 52
Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM O Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr)  O 1.00 2.00					0	0	5. 99
SETTLEMENT TO PROVIDER	.00 Determined net settlement amount (balance due) based on	۱					6. 00
1.02   SETTLEMENT TO PROGRAM   0   481,897   6.00   1.327,938   3,344,937   7.00   1							
7.00         Total Medicare program liability (see instructions)         1,327,938         3,344,937         7.4           Contractor Number (Mo/Day/Yr)           0         1.00         2.00				168, 63	36	1	6.01
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00				4 227	0		6. 02
Number         (Mo/Day/Yr)           0         1.00         2.00	.UU     IOTAL MEGICATE program   IABLILITY (SEE INSTRUCTIONS)			1, 327, 93			7.00
0 1.00 2.00							
			(	0			
	.00 Name of Contractor			=		2.00	8. 00

		Component	CCN. 15-2305	10 09/30/2023	2/27/2024 9: 3	
		Title	XVIII S	Swing Beds - SNF		
		Inpatien	Inpatient Part A Part B		t B	
		mm /dd /\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Amount	mm /dd /> a a a /	Amount	
		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	1, 028, 85		4.00	1.00
2.00	Interim payments payable on individual bills, either			0	0	
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	
3. 02			l .	0	0	
3. 03				0	0	
3. 04				0	0	
3. 05				0	0	3. 05
0 50	Provi der to Program					0.50
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3. 51				0	0	
3. 52				0	0	
3. 53 3. 54				0	0	
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
3. 77	3. 50-3. 98)					3.77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 028, 85	8	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 523, 53		_	
	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 Provi der		1	_	_	
5. 01	TENTATI VE TO PROVI DER			0	0	
5. 02				0	0	
5. 03	Provider to Program			O	0	5.03
5. 50	TENTATIVE TO PROGRAM			0	0	5.50
5. 51	TENTATIVE TO FROGRAM			0	0	
5. 52				0	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	0	
0. 77	5. 50-5. 98)					0.77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		81, 17	2	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 110, 03		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor	ļ		1	I	8.00

Heal th	Financial Systems PULASKI MEMORIA	L HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCUL	From 10/01/2022 Pa To 09/30/2023 Da				pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7.00
	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	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00
					•

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN:	: 15-1305		Worksheet E-2
				From 10/01/2022	
		Component CCN	N: 15-Z305	To 09/30/2023	Date/Time Prepared:
					2/27/2024 9:32 am

		Component CCN: 15-Z305	To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
		Title XVIII	Swing Beds - SNF		- Z aiii
			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)		966, 638	0	
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	178, 160	0	2.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi			U	3.00
	instructions)	ng bed pass till dagn, 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		353	0	
6. 00	Interns and residents not in approved teaching program (see i			0	
7.00	Utilization review - physician compensation - SNF optional me	thod only	1 144 700		7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		1, 144, 798	0	
10.00	Subtotal (line 8 minus line 9)		1, 144, 798	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	1, 144, 770	0	
	professional services)	oast o to pilyot of all		Ū	
12.00	Subtotal (line 10 minus line 11)		1, 144, 798	0	12.00
13.00	Coinsurance billed to program patients (from provider records	) (exclude coinsurance	12, 114	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (see instructions)		1, 132, 684	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50 16. 55	Pioneer ACO demonstration payment adjustment (see instruction Rural community hospital demonstration project (§410A Demonst		0		16. 50 16. 55
10. 55	adjustment (see instructions)	ration) payment	0		10.55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		0	0	1
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
	Total (see instructions)		1, 132, 684	0	
	Sequestration adjustment (see instructions)		22, 654	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs		0	0	19. 03 19. 25
	Sequestration for non-claims based amounts (see instructions) Interim payments		1, 028, 858	0	1
	Interim payments-PARHM		1,020,030	O	20.01
	Tentative settlement (for contractor use only)		0	0	1
	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)	81, 172	0	22.00
	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				-
200 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year 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				1
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	е		202.00
000 00	200 (title XVIII swing-bed SNF))				000 00
	Total (sum of lines 201 and 202)				203. 00 204. 00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demons	tration	J204. 00
	period)	Thist year of the curre	irt 5-year demons	iti ati on	
205.00	Medicare swing-bed SNF target amount				205.00
206.00	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 Reimburs	sement			
	Program reimbursement under the §410A Demonstration (see inst				207.00
208. 00	.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1				208. 00
200 22	and 3)	ati ana)			200 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	CTIONS)			209. 00 210. 00
∠10.00	Reserved for future use Comparision of PPS versus Cost Reimbursement				J2 10. 00 
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
5. 50	instructions)	, p. 11 2 (300			
					•

Health Financial Systems	PULASKI MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1305		Worksheet E-2
			From 10/01/2022	
		Component CCN: 15-Z305	To 09/30/2023	Date/Time Prepared:
				2/27/2024 9:32 am

		Component CCN: 15-Z305	To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
		Title XIX	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00	
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		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
	instructions)				
5.00	Program days		0		5.00
6. 00 7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional me		0		6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thou only	0		8.00
9. 00	Primary payer payments (see instructions)		0		9.00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0		11.00
12. 00	professional services) 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
16. 00 16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	e)	0		16.00
16. 55	Rural community hospital demonstration project (§410A Demonstr	•			16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0		16. 99
17.00	Allowable bad debts (see instructions)		0		17.00
17. 01 18. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insti	ructions)	0		17. 01 18. 00
19. 00	Total (see instructions)	deti ons)	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. 25	Sequestration adjustment-PARHM pass-throughs		0		19. 03 19. 25
20.00	Sequestration for non-claims based amounts (see instructions) Interim payments		0		20.00
	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 22. 01	Balance due provider/program (line 19 minus lines 19.01, 19.0)	2, 19.25, 20, and 21)	0		22. 00 22. 01
23. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0		23. 00
20.00	chapter 1, §115.2				20.00
	Rural Community Hospital Demonstration Project (§410A Demonst				
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	Э		202. 00
3U3 UC	200 (title XVIII swing-bed SNF))  Total (sum of lines 201 and 202)				203.00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
	peri od)		-		
	Medicare swing-bed SNF target amount	imaa lina 204)			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				206. 00
207.00	Program reimbursement under the §410A Demonstration (see inst				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-:	•	1		208. 00
00-	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209.00
Z 10. UC	Reserved for future use Comparision of PPS versus Cost Reimbursement				210. 00
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line :	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1305	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/27/2024 9:32 am
		Title XVIII	Hosni tal	Cost

				2/27/2024 9: 3	2 am
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 450, 931	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3. 00	Organ acquisition	,		0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			1, 450, 931	4.00
5. 00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 465, 440	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			17 1007 110	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			Ö	8.00
9. 00	Organ acquisition charges, net of revenue			0	9.00
10. 00	Total reasonable charges			0	10.00
10.00	Customary charges			Ü	10.00
11. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	11.00
12. 00	Amounts that would have been realized from patients liable fo				12.00
	had such payment been made in accordance with 42 CFR 413.13(e	. 3	a onal go baoi c		12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	,		0. 000000	13.00
14. 00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete on	lvifline 14 exceeds li	ne 6) (see	Ö	15.00
10.00	instructions)	Ty TT TTTIC TT CACCCUS TT	110 0) (300	J	10.00
16. 00	Excess of reasonable cost over customary charges (complete on	lv if line 6 exceeds lin	ne 14) (see	0	16. 00
	instructions)	. 9	.0 11) (000	Ŭ	10.00
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	. 461. 61.67		Ü	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4 line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	.,		1, 465, 440	
20. 00	Deductibles (exclude professional component)			125, 023	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 340, 417	22. 00
23. 00	Coi nsurance			0	23.00
24. 00	Subtotal (line 22 minus line 23)			1, 340, 417	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		22, 496	
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see Thisti deti ons)		14, 622	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		4, 352	27.00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	r de trons)		1, 355, 039	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	e)		Ö	29.50
29. 98	Recovery of accelerated depreciation.	3)		0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 355, 039	30.00
30. 01	Sequestration adjustment (see instructions)			27, 101	
30. 02	Demonstration payment adjustment amount after sequestration			27, 101	30. 02
30. 03	Sequestration adjustment-PARHM			Ŭ	30. 03
31. 00	Interim payments			1, 159, 302	
31. 01	Interim payments-PARHM			1, 10,, 302	31.00
32. 00	Tentative settlement (for contractor use only)			0	32.00
32. 00	Tentative settlement-PARHM (for contractor use only)				32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0	2 31 and 32)		168, 636	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32 01)	100, 000	33. 00
34. 00	Protested amounts (nonallowable cost report items) in accorda			0	34. 00
5 1. 00	\$115. 2	W til Smo l ub. 13-2,	5ap (6) 1,		51.00
	13				

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-1305	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2024 9:32 am

			10 09/30/2023	2/27/2024 9: 3	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		31, 481		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		31, 481	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		31, 481	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		5, 349		8.00
9.00	Ancillary service charges		52, 135	0	
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)		57, 484	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for	1 3	0	0	14.00
45 00	a charge basis had such payment been made in accordance with 42	2 CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	
16.00	Total customary charges (see instructions)	1611 1/	57, 484	0	
17. 00	Excess of customary charges over reasonable cost (complete only	y IT line 16 exceeds	26, 003	0	17.00
10 00	line 4) (see instructions)	, if line 4 evecede line		0	10 00
18. 00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	y II IIIle 4 exceeds IIIle	9	Ü	18. 00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instru	ictions)		0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16		31, 481	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of				21.00
22.00	Other than outlier payments	somproted for the protect	0	0	22.00
	Outlier payments		o	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		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)		31, 481	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		31, 481	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		31, 481	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		31, 481	0	
			0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		31, 481	0	
41.00	Interim payments		22, 582	0	
42.00	Balance due provider/program (line 40 minus line 41)		8, 899	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		1

Health Financial Systems

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

Provi der CCN: 15-1305

Peri od: Worksheet G From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/27/2024 9: 32 am

		Cararal Frank	C: 6: -	F	2/27/2024 9: 3	2 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS	11.00	2.00	0.00	11.00	
1.00	Cash on hand in banks	1, 140, 259	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4. 00	Accounts recei vable	13, 712, 483		0	0	4. 00
5. 00	Other recei vable	224, 696		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable		1	0	0	6. 00
7.00	Inventory	662, 953	1	0	0	
8. 00	Prepai d expenses	46, 544	1	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	4, 167, 290	0	0	0	9.00
11. 00	Total current assets (sum of lines 1-10)	11, 350, 416	- 1	0	0	
11.00	FIXED ASSETS	11, 330, 410	ı	<u> </u>	0	11.00
12. 00	Land	236, 907	0	0	0	12.00
13.00	Land improvements	432, 594		0	0	
14.00	Accumulated depreciation	-457, 469	1	0	0	14.00
15.00		13, 253, 038	0	0	0	15.00
16.00	Accumulated depreciation	-9, 662, 204	0	0	0	16.00
17.00	Leasehold improvements	187, 055	0	0	0	17. 00
18.00		-207, 105	1	0	0	18. 00
	Fixed equipment	7, 732, 825	1	0	0	19. 00
20.00		-7, 698, 063		0	0	
21.00		0	0	0	0	21.00
22.00		0	0	0	0	
23. 00		17, 613, 376		0	0	23.00
24. 00	Accumul ated depreciation Minor equipment depreciable	-9, 528, 874	0	0	0	24.00
25.00	Accumulated depreciation	0		0	0	25. 00 26. 00
27.00	HIT designated Assets	0		0	0	
	Accumul ated depreciation	0		0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	0	Ö	0	0	
30.00		11, 902, 080		0		
	OTHER ASSETS	,,				1
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00		14, 435, 441		0	0	
35.00	Total other assets (sum of lines 31-34)	14, 435, 441	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	37, 687, 937	0	0	0	36.00
27 00	CURRENT LIABILITIES	1 115 747	0	0	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	1, 445, 767 2, 227, 259		0	0	
39. 00	Payroll taxes payable	2,221,239		0	0	39.00
	Notes and Loans payable (short term)	893, 449		0	0	
41. 00	Deferred income	0,0,11,	l o	0	0	1
42. 00		0		J	, , , , , , , , , , , , , , , , , , ,	42.00
43. 00	Due to other funds	Ö	o	0	0	1
44.00	Other current liabilities	1, 005, 555	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5, 572, 030	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	7, 236, 419	0	0	0	
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	-1, 859, 304		0	0	
50.00	,	5, 377, 115		0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	10, 949, 145	0	0	0	51.00
F2 00	CAPITAL ACCOUNTS	27 720 702				F2 00
52.00	General fund balance	26, 738, 792	0			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		١	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			O	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	26, 738, 792	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	37, 687, 937	0	0	0	60.00
	[59]					1

Provider CCN: 15-1305

| Peri od: | Worksheet G-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: | Date/Greek | Prepared: | Prep

					To	09/30/2023	Date/Time Pre 2/27/2024 9:3	
		Genera	Fund	Speci al	Pur	pose Fund	Endowment	
							Fund	
		1.00	0.00	2.00	_	4.00	F 00	
1 00	Fund balances at beginning of period	1. 00	2. 00 24, 557, 749	3.00	-	4. 00	5. 00	1.00
1. 00 2. 00	Net income (loss) (from Wkst. G-3, line 29)		24, 557, 749			U		2.00
3. 00	Total (sum of line 1 and line 2)		26, 738, 792			0		3.00
4. 00	Additions (credit adjustments) (specify)	0	20,700,772		0	Ŭ.	0	4.00
5. 00	(, (, (, (,	0			0		0	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9.00	T	0			0		0	9.00
10.00	Total additions (sum of line 4-9)		0 720 702			0		10. 00 11. 00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	26, 738, 792		0	U	0	12.00
13. 00	beductions (debit adjustillents) (specify)	0			0		0	13.00
14. 00		0			0		0	14.00
15. 00		0			0		Ō	15.00
16.00		0			0		0	16.00
17. 00		0			0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		26, 738, 792			0		19. 00
	sheet (line 11 minus line 18)	Endowment	DLant	L Fund				
		Fund	rrant	runu				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0			_			2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	U	0		0			3. 00 4. 00
5. 00	Additions (credit adjustillents) (specify)		0					5.00
6. 00			0					6.00
7. 00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0	_		0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13. 00 14. 00			0					13. 00 14. 00
15. 00			0					15.00
16. 00			0					16.00
17. 00			0					17.00
18. 00	Total deductions (sum of lines 12-17)	О	_		0			18.00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)			l				

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

		-	To 09/30/2023	Date/Time Pre 2/27/2024 9:3	pared:
	Cost Center Description	Inpatient	Outpati ent	Total	Z alli
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	1, 236, 61	3	1, 236, 613	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	131, 24		131, 245	5.00
6.00	Swing bed - NF	62, 83	4	62, 834	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, 430, 69	2	1, 430, 692	10.00
	Intensive Care Type Inpatient Hospital Services		. 1		
11. 00	INTENSIVE CARE UNIT	1	O	0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE 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
17. 00	11-15)	1 420 40		1 420 402	17. 00
18.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	1, 430, 69 10, 027, 79		1, 430, 692 65, 192, 504	18.00
19. 00	Outpatient services	309, 28		7, 921, 553	19.00
20. 00	RURAL HEALTH CLINIC		5, 513, 229	5, 513, 229	20.00
20. 00	RURAL HEALTH CLINIC II		589, 883	589, 883	20.00
20. 01	RURAL HEALTH CLINIC III		100, 633	100, 633	
20. 02	RURAL HEALTH CLINIC IV		622, 744	622, 744	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		022, 744	022, 744	21.00
22. 00	HOME HEALTH AGENCY	· ·		0	22.00
23. 00	AMBULANCE SERVICES			O	23.00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE	1		0	26.00
27. 00	NON-PROVI DER BASED	•	193, 332	193, 332	27. 00
27. 01	PHYSI CI AN FEES	292, 41		413, 935	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst			81, 978, 505	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)		42, 471, 899		29. 00
30.00	ADD (SPECIFY)	(	o		30.00
31.00					31.00
32.00					32.00
33.00			o		33.00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37.00
38.00			0		38. 00
39. 00			0		39. 00
40.00			0		40.00
41. 00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	sfer	42, 471, 899		43.00
	to Wkst. G-3, line 4)				

Health Financial Cyctems DILACYL MEMORIAL HOCKLEAL	ou of Form CMC (	)EEO 10
Health Financial Systems  PULASKI MEMORIAL HOSPITAL  In Li  STATEMENT OF REVENUES AND EXPENSES  Provider CCN: 15-1305   Period:	eu of Form CMS-2 Worksheet G-3	2552-10
From 10/01/202	2	
To 09/30/2023	3 Date/Time Prep 2/27/2024 9:33	
	7. 27 2024 7. 3	2 (111)
	1.00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81, 978, 505	1.00
2.00 Less contractual allowances and discounts on patients' accounts	44, 161, 313	2.00
3.00 Net patient revenues (line 1 minus line 2)	37, 817, 192	3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	42, 471, 899	4.00
5.00 Net income from service to patients (line 3 minus line 4)	-4, 654, 707	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 services	0	8.00
9.00 Revenue from television and radio service	0	9. 00
10.00 Purchase discounts	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	
15.00 Revenue from rental of living quarters		15.00
16.00 Revenue from sale of medical and surgical supplies to other than patients	1	16.00
17.00 Revenue from sale of drugs to other than patients	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.)		19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00 Rental of vending machines	0	21.00
22.00 Rental of hospital space	0	22.00
23.00 Governmental appropriations	0	23.00
24. 00 OTHER I NCOME_	6, 695, 087	
24. 01 RENTAL INCOME	22, 641	
24. 02 NON OPERATING	145, 071	
24. 50 COVI D-19 PHE Fundi ng	-27, 049	
25.00 Total other income (sum of lines 6-24)	6, 835, 750	
26.00 Total (line 5 plus line 25)	2, 181, 043	
27. 00 OTHER EXPENSES (SPECIFY)	0	27.00
28.00 Total other expenses (sum of line 27 and subscripts)	0	28. 00
29.00 Net income (or loss) for the period (line 26 minus line 28)	2, 181, 043	29.00

		DIN AGAI MEMODI				6.5	
	Financial Systems IS OF HOSPITAL-BASED RHC/FOHC COSTS	PULASKI MEMORI	Provider C	ON 15 1005	In Lie Period:	u of Form CMS-2	
ANALYS	13 OF HOSPITAL-BASED KHC/FUHC COSTS		Provider C		From 10/01/2022	Worksheet M-1	
			Component		To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
					RHC I	Cost	
		Compensation	Other Costs		Reclassi fi cat	Reclassi fied	
				+ 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	5.00	
1. 00	Physician	3, 189, 920	24, 000	3, 213, 92	0 -1, 188, 942	2, 024, 978	1.00
2. 00	Physician Assistant	3, 107, 720	24,000	3, 213, 72	0 1, 100, 742	0	2.00
3.00	Nurse Practitioner	967, 902	54, 200	1, 022, 10	2 -11, 354	1, 010, 748	3.00
4. 00	Visiting Nurse	0	0	1,,	0 0	0	4.00
5.00	Other Nurse	232, 512	0	232, 51	2 0	232, 512	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	54, 149	0	54, 14	9 -26, 004	28, 145	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	755, 163	0	755, 16	3 0	755, 163	9. 00
10.00	Subtotal (sum of lines 1 through 9)	5, 199, 646	78, 200	5, 277, 84		4, 051, 546	1
11. 00	Physician Services Under Agreement	0	0		0 -29, 345	-29, 345	
12.00	Physician Supervision Under Agreement	0	0		0	0	
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 -29, 345	-29, 345	•
15.00	Medical Supplies	0	41, 817	41, 81	7 -8,000	33, 817	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	16. 00 17. 00
17. 00 18. 00	Depreciation-Medical Equipment Professional Liability Insurance	0	0		0	0	18.00
19.00		0	0		0		19.00
20.00	Allowable GME Costs	O <sub>1</sub>	O			0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	41, 817	41, 81	7 -8,000	33, 817	21.00
22. 00	Total Cost of Health Care Services (sum of	5, 199, 646	120, 017			4, 056, 018	•
	lines 10, 14, and 21)	27, 2	,		1, 200, 010	.,,	
	COSTS OTHER THAN RHC/FQHC SERVICES				<u>'</u>	•	
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 23, 706	23, 706	
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 23, 706	23, 706	28. 00
	through 27)						
29. 00	FACILITY OVERHEAD Facility Costs	ol	168, 292	168, 29	2 -7, 842	160, 450	29. 00
30.00	Administrative Costs	726, 519	182, 181	908, 70			
31.00	Total Facility Overhead (sum of lines 29 and		350, 473				1
31.00	30)	720, 317	330, 473	1, 0, 0, 99	511, 122	,00,070	] 31.00

5, 926, 165

470, 490

6, 396, 655

-1, 551, 061

4, 845, 594

32.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS			Peri od: From 10/01/2022	Worksheet M-1
		Component CCN: 15-8512		Date/Time Prepared: 2/27/2024 9:32 am
			RHC I	Cost

						2/27/2024 9: 3	32 am
					RHC I	Cost	
	·	Adjustments	Net Expenses				
		,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00	1			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1. 00	Physi ci an	0	2, 024, 978				1.00
2. 00	Physician Assistant	0	2,024,770	1			2.00
3. 00	Nurse Practitioner	0	1, 010, 748	1			3.00
4. 00	1	0	1,010,740				4.00
5. 00	Visiting Nurse	0	232, 512	<u>'</u>			5.00
	Other Nurse	U		1			1
6.00	Clinical Psychologist	U	00.145	1			6.00
7. 00	Clinical Social Worker	0	28, 145	1			7.00
8. 00	Laboratory Techni ci an	0		1			8.00
9. 00	Other Facility Health Care Staff Costs	0	755, 163				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	4, 051, 546				10.00
11. 00	Physician Services Under Agreement	0	-29, 345	i			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	-29, 345	5			14.00
15.00	Medical Supplies	0	33, 817	·			15.00
16.00	Transportation (Health Care Staff)	o	C				16.00
17.00	Depreciation-Medical Equipment	o	C				17.00
18. 00	1 ' ' '	0	Ċ				18.00
19.00	Other Health Care Costs	0	Ċ				19.00
20. 00	1	-	_				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	33, 817	,			21.00
22. 00	Total Cost of Health Care Services (sum of	0	4, 056, 018				22.00
22.00	lines 10, 14, and 21)	o o	4, 030, 010	'			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
22 00	Pharmacy	O	C	VI.			23.00
24.00	Dental	0	(	1			24.00
25. 00	1	0		()			25.00
	Optometry	0	22 704	'}			25.00
25. 01	Tel eheal th	U	23, 706	2			
25. 02	Chronic Care Management	U	(	<u>'</u>			25. 02
26. 00	All other nonreimbursable costs	U	C	7			26.00
27. 00	Nonallowable GME costs	_					27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	23, 706	p			28. 00
	through 27)						_
	FACILITY OVERHEAD						
	Facility Costs	0	160, 450	•			29. 00
30.00		0	605, 420	1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	765, 870	)			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	4, 845, 594				32.00
	and 31)						

Heal th	Financial Systems	PULASKI MEMORI	AL HOSDITAL		In lie	u of Form CMS-2	2552_10
	IS OF HOSPITAL-BASED RHC/FOHC COSTS	FULASKI WEWOKI	Provi der Co	°N: 15_1305	Peri od:	Worksheet M-1	
AWALIS	NO OF THOSE TIME BASED KNOT QUO GOSTS				From 10/01/2022		
			Component	CCN: 15-8527	To 09/30/2023	2/27/2024 9: 3	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Reclassified	
				+ 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	2.00	3.00	4.00	3.00	
1. 00	Physi ci an	371, 222	36, 000	407, 22	22 88, 635	495, 857	1.00
2. 00	Physician Assistant	0	0	107,2	0 0	0	1
3.00	Nurse Practitioner	0	0		0 -34, 730	-34, 730	3.00
4.00	Visiting Nurse	0	0		0 0	0	1
5.00	Other Nurse	93, 416	0	93, 4°	16 0	93, 416	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 26, 004	26, 004	7.00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	25, 979	0			25, 979	9. 00
10.00	Subtotal (sum of lines 1 through 9)	490, 617	36, 000	526, 6	· ·	606, 526	
11. 00	Physician Services Under Agreement	0	0		0 12, 392	12, 392	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12.040	12.0	0 12, 392	12, 392	
15.00	Medical Supplies	U O	12, 040	12, 04	10 3, 378	15, 418	1
16. 00 17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	0		0	0	
18.00	Professional Liability Insurance	0	0				
19. 00	Other Health Care Costs	0	0			0	1
20.00	Allowable GME Costs	J	Ü			Ĭ	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	12, 040	12.04	3, 378	15, 418	
22. 00	Total Cost of Health Care Services (sum of	490, 617	48, 040	538, 65	· ·	634, 336	1
	lines 10, 14, and 21)				·	· ·	
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	1
24. 00	Dental	0	0		0	0	24. 00
25.00	Optometry	0	0		0	0	25. 00
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		0	0	
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27) FACILITY OVERHEAD						1
29. 00	Facility Costs	0	30, 125	30, 12	25 3, 311	33, 436	29. 00
30.00	Admi ni strati ve Costs	80. 844	21, 574		· ·	105, 750	1
31. 00	Total Facility Overhead (sum of lines 29 and		51, 699		· ·	139, 186	1
2 20	30)	22,011	, 0 , ,		270.0		

571, 461

99, 739

671, 200

102, 322

773, 522

32.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1305	From 10/01/2022	
	Component CCN: 15-8527		Date/Time Prepared: 2/27/2024 9:32 am

			Component	CCN. 13-0327	10 04/30/2023	2/27/2024 9: 32	
					RHC II	Cost	
		Adjustments	Net Expenses				
		•	for				
			Allocation				
			(col. 5 +				
			col . 6)				
		6. 00	7. 00				
<u> </u>	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	495, 857				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	-34, 730				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	93, 416				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	26, 004				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	25, 979				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	606, 526				10.00
11.00	Physician Services Under Agreement	0	12, 392				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, 392				14.00
15.00	Medical Supplies	0	15, 418				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15, 418				21.00
22.00	Total Cost of Health Care Services (sum of	O	634, 336				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25. 01	Tel eheal th	0	0				25.01
25. 02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	33, 436				29.00
30.00	Administrative Costs	0	105, 750	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	139, 186				31.00
	30)						
32.00	, ,	0	773, 522				32.00
	and 31)			l		ļ	

	Financial Systems	PULASKI MEMORI				u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 10/01/2022	Worksheet M-1	
			Component		To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
					RHC III	Cost	
		Compensation	Other Costs		Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS		0		0/ 000	07,000	4 00
1.00	Physi ci an	0	0	1	0 26, 002	26, 002	1.00
2.00	Physician Assistant	70 440	0		0 0	0	2.00
3.00	Nurse Practitioner	78, 442	10, 000	88, 44	2 31, 663	120, 105	1
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	0	0		0	0	
6.00	Clinical Psychologist	U	0		0	0	6.00
7.00	Clinical Social Worker	U	0		0	0	7.00
8. 00 9. 00	Laboratory Technician	20 140	0	20.14	0	0	8.00
	Other Facility Health Care Staff Costs	29, 140	10.000	29, 14		29, 140	1
10. 00 11. 00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	107, 582	10, 000	117, 58	2 57, 665 0 4, 220	175, 247 4, 220	
12.00	Physician Supervision Under Agreement	0	0		4, 220	4, 220	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 4, 220	4, 220	
15. 00	Medical Supplies	0	4, 329	l .		5, 479	
16. 00	Transportation (Health Care Staff)	0	4, 327	4, 32	1, 130	0,479	16.00
17. 00	Depreciation-Medical Equipment	0	0			0	17.00
18. 00	Professional Liability Insurance	0	0			0	18.00
19. 00	Other Health Care Costs	0	0		0	0	19.00
20. 00	Allowable GME Costs	J	0		٥		20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	4, 329	4, 32	9 1, 150	5, 479	
22. 00	Total Cost of Health Care Services (sum of	107, 582	14, 329			184, 946	
22.00	lines 10, 14, and 21)	1077 002	. 1, 52,	.2.,,.		.01,710	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0		0	0	25.00
25.01	Tel eheal th	0	0		0 3, 067	3, 067	25. 01
25.02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	o	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 3, 067	3, 067	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	6, 707		·	7, 835	1
30.00	Administrative Costs	27, 350 27, 350	11, 016 17, 723			· ·	30.00

134, 932

17, 723

32, 052

2, 263

68, 365

47, 336

235, 349

31.00

32.00

45, 073

166, 984

Total Facility Overhead (sum of lines 29 and

Health Financial Systems	PULASKI MEMORIAL HOS	PI TAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Pro		Peri od: From 10/01/2022	Worksheet M-1
	Con	nponent CCN: 15-8528	To 09/30/2023	
			D110 111	<u> </u>

						2/27/2024 9: 3	32 am
				_	RHC III	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	26, 002	2			1.00
2.00	Physician Assistant	0	C	)			2.00
3.00	Nurse Practitioner	0	120, 105	5			3.00
4.00	Visiting Nurse	0	C	)			4.00
5.00	Other Nurse	0	C				5.00
6.00	Clinical Psychologist	0	C				6.00
7.00	Clinical Social Worker	0	C				7.00
8.00	Laboratory Techni ci an	0	C				8.00
9.00	Other Facility Health Care Staff Costs	0	29, 140				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	175, 247	'			10.00
11.00	Physician Services Under Agreement	0	4, 220				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	4, 220				14.00
15. 00	Medical Supplies	0	5, 479				15.00
16.00	1 ''	0	C	1			16.00
	Depreciation-Medical Equipment	0	C				17.00
	Professional Liability Insurance	0	C				18.00
	Other Health Care Costs	0	Ċ				19.00
20.00	Allowable GME Costs	-					20.00
21. 00		0	5, 479				21.00
22. 00	Total Cost of Health Care Services (sum of	0	184, 946				22.00
	lines 10, 14, and 21)	_					
	COSTS OTHER THAN RHC/FQHC SERVICES			<b>'</b>			1
23.00	Pharmacy	0	C				23.00
24.00	1	0	C				24.00
25.00	Optometry	0	C				25.00
25. 01	Tel eheal th	0	3, 067	,			25. 01
25. 02		0	C	1			25. 02
26.00	All other nonreimbursable costs	0	C				26.00
27. 00	Nonallowable GME costs	-					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	3, 067	,			28. 00
	through 27)	_	-,				
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	7, 835	5			29. 00
30.00	Administrative Costs	0	39, 501	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	47, 336				31.00
550	30)	J	, 000				353
32.00	Total facility costs (sum of lines 22, 28	0	235, 349				32.00
	and 31)	J					
	,	'	1	1			•

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component (		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
					RHC IV	Cost	
		Compensation	Other Costs	Total (col. '	Reclassi fi cat	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	222 242	45 000	205.01	07.440	0/0.010	
1.00	Physi ci an	320, 262	15, 000		·	362, 910	1.00
2.00	Physician Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	121, 228	12, 000	133, 22		133, 228	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	0	0		0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0			0	7.00
8. 00	Laboratory Technician	٩	0		0	_	8. 00 9. 00
9. 00 10. 00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	60, 366 501, 856	27, 000	60, 36 528, 85		60, 366 556, 504	
11.00	Physician Services Under Agreement	501,856	27,000		0 12,733	12, 733	11.00
12.00	Physician Supervision Under Agreement	0	0		0 12, 733	12,733	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 12, 733	12, 733	
15. 00	Medical Supplies	0	0		0 12, 733	3, 471	•
16. 00	Transportation (Health Care Staff)	0	0		0 3, 471	3,4/1	16.00
17. 00	Depreciation-Medical Equipment	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	Ŭ	J				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0 3, 471	3. 471	
22. 00	Total Cost of Health Care Services (sum of	501, 856	27, 000	528, 85		572, 708	22.00
	lines 10, 14, and 21)	221, 222		,	,		
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0		0	0	25.00
25.01	Tel eheal th	0	0		0	0	25. 01
25.02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	44, 761	44, 76	·	46, 174	1
30.00	Administrative Costs	29, 300	24, 415	53, 71	·	57, 139	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	29, 300	69, 176	98, 47	6 4, 837	103, 313	31.00
	(30)			i e			l .

531, 156

96, 176

627, 332

48, 689

676, 021

32.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1305	From 10/01/2022	
	Component CCN: 15-8554	To 09/30/2023	Date/Time Prepared: 2/27/2024 9:32 am

			Component	CCN. 15-6554	10	09/30/2023	2/27/2024 9:3	
						RHC IV	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	362, 910					1.00
2.00	Physi ci an Assi stant	0	0	ı				2.00
3.00	Nurse Practitioner	0	133, 228					3.00
4.00	Visiting Nurse	0	0					4.00
5.00	Other Nurse	0	0					5.00
6.00	Clinical Psychologist	0	0					6. 00
7. 00	Clinical Social Worker	0	0	ı				7. 00
8. 00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	60, 366					9.00
10.00	Subtotal (sum of lines 1 through 9)	0	556, 504					10.00
11.00	Physician Services Under Agreement	0	12, 733	1				11.00
12.00	Physician Supervision Under Agreement	U O	0					12.00
13.00	Other Costs Under Agreement	U O	12.722					13. 00 14. 00
14. 00 15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	O O	12, 733 3, 471					15.00
16. 00	Transportation (Health Care Staff)	0	3, 4/1	•				16.00
17. 00	Depreciation-Medical Equipment	0	0					17. 00
18. 00	Professional Liability Insurance	0	0					18. 00
19. 00	Other Health Care Costs	0	0					19. 00
20. 00	Allowable GME Costs	Ĭ	Ü					20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	3, 471					21.00
22. 00	Total Cost of Health Care Services (sum of	ol	572, 708					22.00
	lines 10, 14, and 21)		,					
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0					23.00
24.00	Dental	0	0					24.00
25.00	Optometry	0	0					25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0	1				25. 02
26. 00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							
20.00	FACILITY OVERHEAD	12 222	22.000					20.00
	Facility Costs	-13, 092	33, 082	•				29. 00
30.00	Administrative Costs	12 002	57, 139					30.00
31. 00	Total Facility Overhead (sum of lines 29 and 30)	-13, 092	90, 221					31.00
32. 00	Total facility costs (sum of lines 22, 28	-13, 092	662, 929					32.00
32.00	and 31)	- 13, 072	002, 727					32.00
	Julia 01)	I		I				1

	Financial Systems	PULASKI MEMORI	I AL_HOSPI TAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Period: From 10/01/2022	Worksheet M-2	
			Component		To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		T				
1. 00	Physi ci an	5. 77					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	1.74					3. 00
4. 00	Subtotal (sum of lines 1 through 3)	7. 51	•		27, 888		1
5. 00	Visiting Nurse	0.00	l e			0	
6. 00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	1. 81				1, 565	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
0.00	only)	0.00	0.4.000			00.450	0.00
8. 00	Total FTEs and Visits (sum of lines 4	9. 32	24, 983			29, 453	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9. 00
9.00	Priysi chair Servi ces under Agreements		0			U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL -BASE	ED RHC/EOHC SEI	RVICES		1.00	
	Total costs of health care services (from Wk			KVI OLS		4, 056, 018	10 00
	Total nonreimbursable costs (from Wkst. M-1,					23, 706	
12.00	Cost of all services (excluding overhead) (s					4, 079, 724	•
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 994189	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		765, 870	
15. 00	Parent provider overhead allocated to facili					3, 519, 228	
16.00	Total overhead (sum of lines 14 and 15)	., (***	,			4, 285, 098	
	Allowable GME overhead (see instructions)					0	1
	Enter the amount from line 16					4, 285, 098	
	Overhead applicable to hospital-based RHC/FQ	HC services (I	ine 13 x line	18)		4, 260, 197	
	Total allowable cost of hospital-based RHC/F					8, 316, 215	20.00

Heal th	Financial Systems	PULASKI MEMORI	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8527	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1		1	0 100		
1.00	Physi ci an	0.74					1.00
2.00	Physician Assistant	0.00		_,			2.00
3. 00 4. 00	Nurse Practitioner	1. 45 2. 19			0 3, 045 6, 153	/ 150	3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0.00		•	6, 153	6, 153	4. 00 5. 00
6. 00	Clinical Psychologist	0.00		•		0	6.00
7. 00	Clinical Social Worker	0.00	l .	l .		68	7.00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.37	l .			0	7.00
7. 01	Di abetes Self Management Training (FQHC	0.00				0	7.01
7.02	only)	0.00	0			0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	2. 56	4, 352			6, 221	8. 00
0.00	through 7)	2.00	1, 552			0,22.	0.00
9.00	Physician Services Under Agreements		0			0	9.00
	<del> </del>						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
	Total costs of health care services (from Wk					634, 336	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					634, 336	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		139, 186	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			614, 070	
16. 00	Total overhead (sum of lines 14 and 15)					753, 256	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16			4.0)		753, 256	
	Overhead applicable to hospital-based RHC/FO					753, 256	
20.00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (	Sum OT LINES 10	u and 19)		1, 387, 592	20.00

Heal th	Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	SERVI CES	Provi der C		Peri od: From 10/01/2022	Worksheet M-2	
			Component		To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
					RHC III	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						
	Positions Positions						
1. 00	Physi ci an	0. 04		•	1 0		1.00
2. 00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	0. 69			1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 73			1	1, 482	
5. 00	Visiting Nurse	0.00		•		0	
6. 00	Clinical Psychologist	0.00				0	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			0	7. 02
8. 00	only) Total FTEs and Visits (sum of lines 4	0. 73	1 400			1, 482	8.00
6.00	through 7)	0.73	1, 482			1,402	0.00
9. 00	Physician Services Under Agreements		0			0	9.00
7.00	Thysrcian services under Agreements					0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FOHC SE	RVICES			
10.00	Total costs of health care services (from Wk					184, 946	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					3, 067	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			188, 013	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 983687	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, l	ine 31)		47, 336	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			207, 499	15.00
16.00	Total overhead (sum of lines 14 and 15)					254, 835	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					254, 835	18.00
	Overhead applicable to hospital-based RHC/FC					250, 678	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (	sum of lines 1	0 and 19)		435, 624	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		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
					RHC IV	Cost	
		Number of FTE	Total Visits	Producti vi ty	/ Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	0. 96			1 1		1.00
2.00	Physici an Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	0. 87			1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.83			2	4, 472	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	1 0.00
7.00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	1.83	4, 472			4, 472	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWARIE COCT APPLICABLE T	O HOCDITAL DACI	ED DUC/FOUR CEI	DVII CEC		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from Wk			RVICES		572, 708	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					572,708	1
12.00	Cost of all services (excluding overhead) (s					572, 708	
12.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ino 21)		90, 221	
15. 00				The 31)		468, 707	
16. 00	Parent provider overhead allocated to facili Total overhead (sum of lines 14 and 15)	ty (see mstru	Ctrons)			558, 928	
17. 00	Allowable GME overhead (see instructions)					0 0 0	•
	Enter the amount from line 16					558. 928	
	Overhead applicable to hospital-based RHC/FC	NUC sorvices (1	ino 12 v lino	10\		558, 928	
	Total allowable cost of hospital-based RHC/F					1, 131, 636	1
20.00	Tiotal allowable cost of hospital-based knc/r	UNC SELVICES (	Jun UI IIIICS I	0 anu 17)	ļ	1, 131, 030	20.00

11 1. 11.	Files I de Control MENORIA	HOODITAL		. C. E OHC	NEEO 40
	Financial Systems PULASKI MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Period:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 15-8512	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
		Title XVIII	RHC I	2/27/2024 9: 3 Cost	2 am
		THE XVIII	KIIC I	0031	
				1. 00	
4 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			0.04/.045	4.00
1. 00 2. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro Cost of injections/infusions and their administration (from W	The state of the s		8, 316, 215 186, 748	1. 00 2. 00
3. 00	Total allowable cost excluding injections/infusions (line 1 m			8, 129, 467	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			29, 453	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)			29, 453	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	276. 01	7. 00
			Carcuration	OI LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	232. 77	246. 69	8. 00
9.00	Rate for Program covered visits (see instructions)	,	232. 77	246. 69	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		1, 272	4, 348	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	296, 083 14	1, 072, 608 29	12.00
13. 00	Program covered cost from mental health services (line 9 x li		3, 259	7, 154	
14.00	Limit adjustment for mental health services (see instructions	· ·	3, 259	7, 154	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	,			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	1, 379, 104	
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov			785, 653 41, 269	
16. 02	Total program preventive charges (see First detroils) (110m prov Total program preventive costs ((line 16.02/line 16.01) times	•		72, 442	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	*		965, 285	
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	1, 037, 727	16.05
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 100, 056	17. 00 18. 00
10.00	records)	(110m contractor		100, 030	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		128, 824	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 037, 727	20. 00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		72, 292	21.00
22. 00				1, 110, 019	
23. 00 23. 01	Allowable bad debts (see instructions)			0	23. 00 23. 01
24. 00	1 3	ructions)		0	24.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	i de ti olis)		Ö	
25.50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			1, 110, 019	
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			22, 200 0	26. 01 26. 02
27. 00	, , , ,			1, 017, 421	
	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			70, 398	
30. 00	,	ince with CMS Pub. 15-II	,	0	30. 00
	chapter I, §115.2		I		I

11 1.11.	Fire tal 6 at a fire tal 6	HOODITAL		. C. E OHO . 6	NEEO 40
	Financial Systems PULASKI MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC		Period:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 15-8527	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
-		Title XVIII	RHC II	2/27/2024 9: 3 Cost	<u>z am</u>
		11 (10 /////	1	3331	
				1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES  Total Allowable Cost of hospital-based RHC/FOHC Services (fro	m Wkst M 2 lino 20)		1, 387, 592	1. 00
2. 00	Cost of injections/infusions and their administration (from W			57, 720	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 m			1, 329, 872	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6, 221	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			6, 221 213. 77	6. 00 7. 00
7.00	Adjusted cost per visit (Title 3 divided by Title 6)		Cal cul ati on		7.00
			our our a troir	01 21 1111 2 (1)	
				Rate Period 2	
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	188. 36	199. 63	8. 00
9. 00	Rate for Program covered visits (see instructions)		188. 36	199. 63	9. 00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	425	856	10. 00
11. 00	Program cost excluding costs for mental health services (line		80, 053	170, 883	
12. 00	Program covered visits for mental health services (from contr	,	7	9	12.00
13.00	Program covered cost from mental health services (line 9 x li	,	1, 319	1, 797	13.00
14.00	Limit adjustment for mental health services (see instructions	•	1, 319	1, 797	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	254, 052	15. 00 16. 00
16. 00	Total program charges (see instructions) (from contractor's re	,	0	164, 191	
16. 02	Total program preventive charges (see instructions) (from prov			4, 692	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	*		7, 260	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		171, 169	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	178, 429	16. 05
17. 00	Pri mary payer amounts			0	17. 00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		32, 831	18.00
10.00	records)	) (6		25 224	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		25, 334	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			178, 429	20. 00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		26, 638	
22. 00	, , , , ,			205, 067	22.00
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 401. 66)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			205, 067	26. 00 26. 01
26. 01	, ,			4, 101 0	26. 01
27. 00	Interim payments			175, 807	27. 00
	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			25, 159	
30. 00	Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2	ince with CMS Pub. 15-11	'	0	30. 00
	O. I.   O. I		l l		l

11 1.116	Fire tal 6 at a fire tal 6	HOCOLTAL		. C. E OHC. (	2550 40
	Financial Systems PULASKI MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Period:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 15-8528	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
		Title XVIII	RHC III	2/27/2024 9: 3 Cost	<u> 2 am</u>
	DETERMINATION OF DATE FOR HOORI THE DAGED DUG (FOUR OFFINATION			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 lino 20)		435, 624	1.00
2. 00	Cost of injections/infusions and their administration (from W			16, 547	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m			419, 077	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1, 482	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) Adjusted cost per visit (line 3 divided by line 6)			1, 482	6.00
7. 00	Adjusted cost per visit (Title 3 divided by Title 6)		Cal cul ati on	282.78 of limit (1)	7.00
			Car car a troir	01 [[1111] [ (1)	
				Rate Period 2	
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	306. 89		8. 00
9. 00	Rate for Program covered visits (see instructions)		282. 78	282. 78	9. 00
10.00	CALCULATION OF SETTLEMENT		0.4	270	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		84 23, 754	279 78, 896	1
12. 00	Program covered visits for mental health services (from contr	,	25, 754	70,070	ı
13.00	Program covered cost from mental health services (line 9 x li		0	0	•
14. 00	Limit adjustment for mental health services (see instructions	•	0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction	•		100 (50	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	102, 650 44, 940	1
16. 01	Total program preventive charges (see instructions)(from prov			3, 194	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		7, 296	•
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		70, 429	16. 04
1/ 05	(Titles V and XIX see instructions.)		0	77 705	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	77, 725 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		7, 318	•
	records)	•			
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		6, 886	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			77, 725	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		6, 389	1
22. 00	,			84, 114	1
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	, , , , , , , , , , , , , , , , , , , ,			0	
24.00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		Ö	
25. 99	Demonstration payment adjustment amount before sequestration	-,		0	1
26. 00	Net reimbursable amount (see instructions)			84, 114	1
26. 01	Sequestration adjustment (see instructions)			1, 682	
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 87, 295	•
	Tentative settlement (for contractor use only)			07, 293	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		-4, 863	1
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	,	0	30.00
	chapter I, §115.2				l

	Financial Systems PULASKI MEMORIAL			u of Form CMS-2	
SERVI (	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1305	Peri od: From 10/01/2022	Worksheet M-3	
02		Component CCN: 15-8554	To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
		Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 131, 636	
2. 00 3. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			9, 148 1, 122, 488	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	11163 11116 2)		4, 472	
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)			4, 472	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	251.00	7.00
			Carcuration	OI LIMIT (I)	
			Rate Period 1		
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	203. 35	215. 51	8.00
9. 00	Rate for Program covered visits (see instructions)		203. 35	215. 51	9.00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	270	777	10.00
11. 00	Program cost excluding costs for mental health services (line	•	54, 905	167, 451	
12.00	Program covered visits for mental health services (from contr	•	0	1	12.00
13.00	Program covered cost from mental health services (line 9 x li	*	0	216	
14.00	Limit adjustment for mental health services (see instructions	•	0	216	
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	222, 572	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re	•	Ĭ	133, 516	1
16. 02	Total program preventive charges (see instructions) (from prov			8, 050	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		13, 419	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		155, 351	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		o	168, 770	16.05
17. 00	Pri mary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		14, 964	18. 00
10 00	records)	no) (from contractor		22 071	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	iis) (ITOIII COITTI actor		22, 071	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			168, 770	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		3, 892	
22. 00	, , ,			172, 662	1
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23.00
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25.00		,		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			172 442	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			172, 662 3, 453	1
26. 02	, ,			0, 433	1
27. 00	Interim payments			165, 513	
	Tentative settlement (for contractor use only)			0	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.			3, 696	
30. 00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	TICE WITH CMS PUB. 15-11	'	0	30.00

rovider CC		Peri od: From 10/01/2022	Worksheet M-4	
	CCN: 15-8512	To 09/30/2023	Date/Time Prep 2/27/2024 9: 3:	
Title		RHC I	Cost	
MOCOCCAL CCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
1. 00	2.00	2. 01	2. 02	
4, 051, 546 0. 000432	4, 051, 54 0. 00192		4, 051, 546 0. 000000	1. 00 2. 00
1, 750	7, 78	4, 234	0	3.00
23, 670	22, 32	31, 320	0	4. 0
25, 420 4, 056, 018	30, 10 4, 056, 01		0 4, 056, 018	5. 00 6. 00
4, 260, 197 0. 006267	4, 260, 19 0. 00742		4, 260, 197 0. 000000	7. 0 8. 0
26, 699 52, 119	31, 62 61, 73		0	9. 00 10. 00
108 482. 58	48 128. <i>6</i>		0 0. 00	12.0
17	21		0	13. 0
8, 204	27, 77	0 78 36, 310	0	
0, 204	21, 11	30, 310	o l	14.0
		1 00		
	col umns 1,	1.00	186, 748	15. 0
	s (sum of		72, 292	16. C
t	line 2) tion costs	ts (sum of columns 1, line 2) tion costs (sum of Wkst. M-3, line 21)	1.00 ts (sum of columns 1, line 2) tion costs (sum of	INFUSIONS AND ADMINISTRATION N   1.00   2.00   1.

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od: From 10/01/2022	Worksheet M-4	
		Component (		To 09/30/2023	Date/Time Prep 2/27/2024 9:3	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	606, 526 0. 000350			606, 526 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	212	5, 00	1, 925	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	1, 903	6, 18	11, 160	0	4.00
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from	2, 115 634, 336			0 634, 336	
	Worksheet M-1, col. 7, line 22)				·	
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	753, 256 0. 003334			753, 256 0. 000000	
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration	2, 511 4, 626	13, 28 24, 47		0	
	costs (sum of lines 5 and 9)					
1.00	Total number of injections/infusions (from your records)	28				11.0
2.00	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	165. 21 10	101. 1 10		0. 00 0	
	benefi ci ari es	10	10			
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 652	10, 21	3 14, 773	0	14.0
					COST OF INJECTIONS /	
					ADMINISTRATIO	
				1. 00	N 2. 00	
5. 00	Total cost of injections/infusions and their administratio		f columns 1,	1.00	57, 720	15.0
6 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. Total Program cost of injections/infusions and their admin		e (sum of		26, 638	16 0
6.00	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou		•		20, 030	16.0

	Financial Systems PULASKI MEMOR .TION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der Co	CN: 15-1305	Peri od:	u of Form CMS-2 Worksheet M-4	
				From 10/01/2022		
		Component	CCN: 15-8528	To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
			XVIII	RHC III	Cost	
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
		1.00	2.00	2.01	PRODUCTS	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1. 00 175, 247		2. 01 17 175, 247	2. 02 175, 247	1.00
	Ratio of injection/infusion staff time to total health	0. 002111		•	· ·	
	care staff time	0.002111	0.00300	0.00000	0.000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line	370	88	86 0	0	3. 00
	2)	2 ((0	2 10	2		4 00
	Injections/infusions and related medical supplies costs (from your records)	3, 668	2, 10	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4, 038	2, 98	0	0	5.00
	Total direct cost of the hospital-based RHC/FQHC (from	184, 946	184, 94	184, 946	184, 946	6. 00
	Worksheet M-1, col. 7, line 22)	050 (70	050 /	20 050 (70	050 (70	7 00
	Total overhead (from Wkst. M-2, line 19)	250, 678 0. 021833		•		7.00
	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.021833	0.01615	0.000000	0.000000	8. 00
	Overhead cost - injection/infusion (line 7 x line 8)	5, 473	4.04	19	o	9.00
	Total injection/infusion costs and their administration	9, 511			Ö	10.00
	costs (sum of lines 5 and 9)					
	Total number of injections/infusions (from your records)	15		19 0	0	11.00
	Cost per injection/infusion (line 10/line 11)	634. 07	143. 5		0. 00	
	Number of injection/infusion administered to Program	6	1	0	0	13.00
	beneficiaries					10.01
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
	Program cost of injections/infusions and their	3, 804	2, 58	35 0	0	14.00
	administration costs (line 12 times the sum of lines 13	0,001	2,00	3	, and the second se	
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMINISTRATIO N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio	n costs (sum of	f columns 1,		16, 547	15. 00
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.					
	Total Program cost of injections/infusions and their admin				6, 389	16.00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	nt to Wkst. M-3	3, line 21)			

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od: From 10/01/2022	Worksheet M-4	
		Component (		To 09/30/2023	Date/Time Pre 2/27/2024 9:3	
			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 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	556, 504 0. 000063	556, 50 0. 00222		556, 504 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	35	1, 23	7 0	0	3.0
1. 00	Injections/infusions and related medical supplies costs (from your records)	489	2, 86	9 0	0	4.00
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	524 572, 708	4, 10 572, 70		0 572, 708	5. 00 6. 00
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	558, 928 0. 000915			558, 928 0. 000000	
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	511 1, 035	4, 00 8, 11		0	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	2 517. 50 2	114. 2	0.77 0.00 0.00		11. 00 12. 00 13. 00
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 035	2, 85	7 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		9, 148	15.00
6.00	Total Program cost of injections/infusions and their admin	istration costs	s (sum of		3, 892	16. C

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15- Component CCN: 15	Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 9:32 am

		Component CCN: 15-8512	10 09/30/2023	2/27/2024 9: 32	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			1, 017, 421	1. (
2. 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. (
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. (
01	1 rogram to rrovider			0	3.
. 02				l ől	3. (
. 03					3.
. 04					3.
. 05					3.
. 05	Provider to Program			U	٥.
50	Trovider to rrogiam			0	3.
51					3.
52					3.
53					3.
					3.
54	C. ht-t-1 (6   i 2 01 2 40 minus 6   i 2 50 2	00)			
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.		_	۱ ۱	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	ster to worksheet M-3, Time	е	1, 017, 421	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk roviow. Also show data	of		5.
00	each payment. If none, write "NONE" or enter a zero. (1)	SK FeVIew. ALSO SHOW date (	OI		٥.
04	Program to Provider				_
01				0	5.
02				0	5.
03	Decided to December 1			0	5.
	Provi der 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	e cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			70, 398	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			1, 087, 819	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F		Provider CCN: 15-1305	Peri od: From 10/01/2022	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIARI	E2	Component CCN: 15-8527		Date/Time Prepared: 2/27/2024 9:32 am

		Component CCN: 15-8527	10 09/30/2023	2/27/2024 9: 32	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			175, 807	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. (
01				0	3. 0
02				ol ol	3. 0
03				ol ol	3. (
04				o o	3. (
05				0	3.
03	Provider to Program			0	٥.
50	i rovi dei 10 i rogi alli			0	3.
51				l ől	3.
52					3.
52 53					3.
54					3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			175, 807	3. 4.
00	27)	Tel to worksheet w-5, Title	-	175, 607	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desleach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	of		5.
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				ol	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		ol ol	5.
00	Determined net settlement amount (balance due) based on the				6.
01	SETTLEMENT TO PROVIDER	opo. c. (.)		25, 159	6.
02	SETTLEMENT TO PROGRAM			25, 137	6.
	Total Medicare program liability (see instructions)			200, 966	7.
			1	200, 700	/.
	medical e program rrabitity (see riistraetrons)		Contractor	NPR Date	
	Total medicale program trabitity (see thistractions)		Contractor	NPR Date	
00	Total mearcure program trabitity (see thistraetrons)	0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	

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		Provi der CCN: 15-1305	Peri od: From 10/01/2022	
		Component CCN: 15-8528	10 09/30/2023	2/27/2024 9:32 am
			DUC LLI	C+

		Component CCN. 13-0320	10 077 307 2023	2/27/2024 9: 32	
			RHC III	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			87, 295	1.0
2. 00	Interim payments payable on individual bills, either submit			0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3.0
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.
3. 02				0	3.
3. 03				0	3.
3. 04				0	3.
3. 05				0	3.
	Provider to Program				
3. 50				0	3.
. 51				0	3.
. 52				0	3.
. 53				o	3.
. 54				o	3.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		o	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	:	87, 295	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				1
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program				
5. 50				0	5.
. 51				0	5.
. 52				ol	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		o	5.
. 00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
. 01	SETTLEMENT TO PROVIDER			0	6.
. 0 1	SETTLEMENT TO PROGRAM			4, 863	
				82, 432	
. 02	Total Medicare program liability (see instructions)				
. 02	Total Medicare program liability (see instructions)		Contractor	NPR Date	
5. 02	Total Medicare program liability (see instructions)			NPR Date	
5. 02 7. 00	Total Medicare program liability (see instructions)	0	Contractor Number 1.00		

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-1305 Component CCN: 15-8554	From 10/01/2022	

		Component Con. 13-8334	10 097 307 2023	2/27/2024 9: 32	
			RHC IV	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
00	Total interim payments paid to hospital-based RHC/FQHC			165, 513	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	period. If none, write			
	"NONE" or enter a zero				
0	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				
)1				0	3
)2				0	3
)3				0	3
)4				0	3
)5				0	3
	Provider to Program				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
19	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	)	165, 513	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		_		
00	List separately each tentative settlement payment after des	k review. Also show date o	of		Ę
	each payment. If none, write "NONE" or enter a zero. (1)				
1	Program to Provider			0	Ę
2				0	
3				0	Ę
	Provider to Program			0	
0	Tovider to Trogram			0	
1				0	5
2				l ől	E
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		ا	E
Ó	Determined net settlement amount (balance due) based on the cost report. (1)				é
1	SETTLEMENT TO PROVIDER			3, 696	6
2	SETTLEMENT TO PROGRAM			1 0,070	6
00	Total Medicare program liability (see instructions)			169, 209	7
, ,	indicate program readility (300 mate detroils)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	