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: 14-1320 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2024 4: 01 pm] Manually prepared cost report use only Ilf 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
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (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 PARIS COMMUNITY HOSPITAL (14-1320) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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	SI GNATURE STATEMENT	
1	Martin Adams		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	Martin Adams			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	444, 076	1, 146, 404	0	0	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	102, 669	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		335, 219		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		32, 350		0	10. 01
10. 02	RURAL HEALTH CLINIC III	0		39, 346		0	10. 02
10. 03	RURAL HEALTH CLINIC IV	0		49, 443		0	10. 03
10.04	RURAL HEALTH CLINIC V	0		7, 277		0	10.04
10. 05	RURAL HEALTH CLINIC VI	0		0		0	10. 05
200.00	TOTAL	0	546, 745	1, 610, 039	0	0	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex indicated	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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 PARIS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

Heal th	Financial Systems	PARIS COMMUNIT	TY HOSPITA	AL			l r	n Lieu	of For	m CMS-	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	der CO	CN: 14-13		Period: From 01/01/ To 12/31/	′2023 ′2023	Workshe Part I Date/Ti 5/23/20	me Pre	pared:
	1.00	2.00		3. 00			4	4. 00	07 207 20	72 1 1. 0	
	Hospital and Hospital Health Care Co					1					
1. 00 2. 00	Street: 721 EAST COURT STREET City: PARIS	PO Box: State: IL	Zip Cod	م. 610	244_	Count	y: EDGAR				1. 00 2. 00
2.00	CITY. FARIS	Component Name	CCN	CB		ovi der		Paymer	nt Syst	em (P	2.00
		Somponorre mamo	Number	Num		Гуре	Certi fi ed		0, or		
								V	XVIII		
	Hasnital and Hasnital Based Company	1.00	2.00	3.	00 4	4. 00	5. 00	6. 00	7. 00	8.00	
3. 00	Hospital and Hospital-Based Componer Hospital	PARIS COMMUNITY	141320	999	014	1	06/30/2002	N	0	0	3.00
0.00	opi tai	HOSPI TAL				•	00, 00, 2002	''			0.00
4.00	Subprovider - IPF										4. 00
5. 00 6. 00	Subprovi der - IRF Subprovi der - (Other)										5. 00 6. 00
7. 00	Swing Beds - SNF	PARIS COMMUNITY	14Z320	999	914		06/30/2002	N	0	N	7. 00
7.00	oming bods om	HOSPI TAL	1.2020	'''			00, 00, 2002	''		"	
8. 00	Swing Beds - NF										8. 00
9. 00 10. 00	Hospi tal -Based SNF Hospi tal -Based NF										9. 00 10. 00
11. 00	Hospi tal -Based OLTC										11.00
12. 00	Hospital -Based HHA										12.00
13. 00	Separately Certified ASC										13. 00
14. 00 15. 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC	FMC	143987	999	111		09/24/1994	l N	0	N N	14. 00 15. 00
15. 00	Hospital -Based Health Clinic - RHC	HATCH	143989	999			01/01/1995	ı	0	N	15. 00
	H										
15. 02	Hospital-Based Health Clinic - RHC	FMC OAKLAND	148596	999			02/22/2019	N	0	N	15. 02
15. 03	Hospital-Based Health Clinic - RHC	EZ CARE - PARIS	148607	999			09/25/2019		0	N	15. 03
15. 04 15. 05	Hospital-Based Health Clinic - RHC \\ Hospital-Based Health Clinic - RHC	SYCAMORE WELLNESS	148606 158573	999			11/14/2019 11/29/2023		0	N N	15. 04 15. 05
16. 00	Hospital-Based Health Clinic - FQHC										16. 00
17. 00	Hospital -Based (CMHC) I										17. 00
18. 00	Renal Dialysis	HORIZON HEALTH DIALYSIS	142341	999	914		03/01/2023				18. 00
19. 00	Other	CENTER									19. 00
17.00	, o c. 10.						From:		То		
00.00							1.00		2. (00.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/20	023	12/31/	2023	20. 00 21. 00
21.00	Type of control (see That detrois)										21.00
	T				1.	00	2. 00		3. (00	
22. 00	Inpatient PPS Information Does this facility qualify and is it	currently receiving pay	monts for			V	N				22. 00
22.00	disproportionate share hospital adju				'	V					22.00
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §		endment								
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC		al UCPs.	for	,	V	N	ŀ			22. 01
22.0.	this cost reporting period? Enter in					•					
	for the portion of the cost reportir										
	1. Enter in column 2, "Y" for yes or cost reporting period occurring on c	•	tion of th	ne							
	instructions)	or arter october 1. (see									
22. 02	Is this a newly merged hospital that				r	N	N				22. 02
	determined at cost report settlement			umn							
	1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in			no							
	for the portion of the cost reportir			,							
22. 03	Did this hospital receive a geograph				1	N	N		N		22. 03
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in column 1, "Y" for yes or for the portion of the cost reporting period prior to Octobe										
	in column 2, "Y" for yes or "N" for	no for the portion of th	ne cost								
	reporting period occurring on or aft										
	Does this hospital contain at least counted in accordance with 42 CFR 41										
	yes or "N" for no.	, -,	-,								

61. 10	Of the FTEs in line 61.05, specify each new program	0.00	0. 00	61. 10
	specialty, if any, and the number of FTE residents			
	for each new program. (see instructions) Enter in			
	column 1, the program name. Enter in column 2, the			
	program code. Enter in column 3, the IME FTE			
	unweighted count. Enter in column 4, the direct GME			
	FTE unweighted count.			
61. 20	Of the FTEs in line 61.05, specify each expanded	0.00	0.00	61. 20
	program specialty, if any, and the number of FTE			
	residents for each expanded program. (see			
	instructions) Enter in column 1, the program name.			
	Enter in column 2, the program code. Enter in column			
	3, the IME FTE unweighted count. Enter in column 4,			
	the direct GME FTE unweighted count.			

Health Financial Systems		OMMUNITY HOSPITAL			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMF	PLEX IDENTIFICATION DAT	A Provider C	CN: 14-1320	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Pre 5/23/2024 4:0	pared:
					1.00	
ACA Provisions Affecting the Heach 62.00 Enter the number of FTE residen				riod for which	0.00	62.00
your hospital received HRSA PCRI 62.01 Enter the number of FTE residen	E funding (see instruct ts that rotated from a	tions) Teaching Health Cen	ter (THC) int			62. 01
during in this cost reporting per Teaching Hospitals that Claim Re			ns)			<u> </u>
63.00 Has your facility trained reside	ents in nonprovider set	ttings during this c			N	63.00
	,		Unwei ghted FTEs		Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te		2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after.			This base yea	ır is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column	s yes, or your facility mber of unweighted non- ptations occurring in a e number of unweighted our hospital. Enter in	trained residents primary care all nonprovider non-primary care column 3 the ratio	0.	0. 00	0. 000000	64.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4.00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			O. Unwei ahted			
			FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Year FTE Residents in	Nonprovider Setting	1.00 sEffective	2.00 for cost reporti	ng periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospif (column 1 divided by (column 1	unweighted non-primary occurring in all nonpro unweighted non-primary tal. Enter in column 3	ovider settings. / care resident the ratio of	0.	0. 00	0. 000000	66. 00
Teer aim a. vi ded by (cor dilli i i	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4.00	5.00	

0 88.00

Ν

88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target

Column 2: Enter the number of approved permanent adjustments.

amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line

89. (see instructions)

			1. 00	2.00	3.00	1
9.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line	number	0. 00		(89.00
	on which the per discharge permanent adjustment approval was bas					
	Column 2: Enter the effective date (i.e., the cost reporting per					
	peginning date) for the permanent adjustment to the TEFRA target	amount				
	per discharge. Column 3: Enter the amount of the approved permanent adjustment	to the				
	TEFRA target amount per discharge.	to the				
	Eritt target amount per ar senarge.			V	XIX	
				1.00	2.00	1
-	Fitle V and XIX Services					
	Does this facility have title V and/or XLX inpatient hospital se	rvi ces? Er	iter "Y" for	N	Υ	90.00
	es or "N" for no in the applicable column.					
	s this hospital reimbursed for title V and/or XIX through the c		either in	N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicab					
	Are title XIX NF patients occupying title XVIII SNF beds (dual c		on)? (see		N	92. 0
	nstructions) Enter "Y" for yes or "N" for no in the applicable					00.0
. 00	Ooes this facility operate an ICF/IID facility for purposes of t	itie v and	I XIX? Enter	N	N	93.00
00	'Y" for yes or "N" for no in the applicable column.	"N" for no	. i n +ho	NI.	N.	04.0
	Opes title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	IN TOT TIC) III the	N	N	94.00
	fline 94 is "Y", enter the reduction percentage in the applica	ble column	,	0. 00	0.00	95. 0
	Does title V or XIX reduce operating cost? Enter "Y" for yes or			N. 00	0.00 N	96.0
	applicable column.	N TOT TIC) III the	IN	IN IN	70.00
1	fline 96 is "Y", enter the reduction percentage in the applica	ble column	١.	0. 00	0.00	97. 0
	Does title V or XIX follow Medicare (title XVIII) for the intern			Υ	Υ	98. 0
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for y					
	column 1 for title V, and in column 2 for title XIX.					
. 01 I	Does title V or XIX follow Medicare (title XVIII) for the report	ing of cha	irges on Wkst.	Υ	Υ	98. 0
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title	V, and in	column 2 for			
	title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for the calcul			Υ	Y	98. 0
	ped costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N	" for no i	n column 1			
1	for title V, and in column 2 for title XIX.	6	: +-! (CAU)	NI.	N.	00.0
	Opes title V or XIX follow Medicare (title XVIII) for a critical			N	N	98. 0
	eimbursed 101% of inpatient services cost? Enter "Y" for yes or For title V, and in column 2 for title XIX.	N TOLL	io i ii coi uiiii i			
	Does title V or XIX follow Medicare (title XVIII) for a CAH reim	hursed 101	% of	N	N	98. 0
	outpatient services cost? Enter "Y" for yes or "N" for no in col					70.0
	n column 2 for title XIX.		ti ti o vi ana			
	Does title V or XIX follow Medicare (title XVIII) and add back t	he RCE dis	sallowance on	Υ	Υ	98.0
١	Vkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum	n 1 for ti	tle V, and in			
0	column 2 for title XIX.					
	Ooes title V or XIX follow Medicare (title XVIII) when cost reim			Υ	Υ	98. 0
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f	for title V	/, and in			
	column 2 for title XIX.					_
-	Rural Providers					405 0
	Ooes this hospital qualify as a CAH?			Y		105. 0
	f this facility qualifies as a CAH, has it elected the all-incl	usive metr	nod or payment	N		106. 0
	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost r	oi mburcomo	ont for L&D	N		107. 0
	raining programs? Enter "Y" for yes or "N" for no in column 1.			IN		107.0
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you					
	approved medical education program in the CAH's excluded IPF an					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)		(0)			
	f this facility is a REH (line 3, column 4, is "12"), is it eli		cost			107. 0
	reimbursement for I&R training programs? Enter "Y" for yes or "N					
ļi	nstructions)					
	s this a rural hospital qualifying for an exception to the CRNA	fee sched	lul e? See 42	N		108. 0
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	P	hysi cal	Occupati onal	Speech	Respi ratory	
		1. 00	2. 00	3. 00	4.00	10-
	f this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00
	therapy services provided by outside supplier? Enter "Y"					
	for yes or "N" for no for each therapy.				1	1

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		NITY HOSPITAL	N. 14 1220	Don't od		u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	Provi der CC	N: 14-1320		1/01/2023 2/31/2023	Worksheet S-2 Part I Date/Time Pro 5/23/2024 4:0	epared:
							J piii
31.00 f this is a Medicare-certified in	ntestinal transplant prog	ıram, enter the c	erti fi cati		1. 00	2.00	131. 00
date in column 1 and termination of 32.00 If this is a Medicare-certified is	late, if applicable, in c slet transplant program,	column 2. enter the certif					132. 00
in column 1 and termination date, 33.00 Removed and reserved	if applicable, in column	1 2.					133. 0
34.00 If this is a hospital-based organ in column 1 and termination date, All Providers			ne OPO numb	er			134. 0
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 home office chain numbe	f yes, and home er. (see instruct	office cos	ts	N		140. 0
1.00 If this facility is part of a chai		.00 Lines 141 throu	 ah 143 the	name and	3.00 1 address	of the	+
home office and enter the home off	ice contractor name and			rialle and	auui ess	or the	
41. 00 Name: 42. 00 Street:	Contractor's Name: PO Box:		Contra	ctor's Nu	mber:		141. 00
43. 00 Ci ty:	State:		Zip Co	de:			143. 00
	·					1.00	
44.00 Are provider based physicians' cos	sts included in Worksheet	: A?				1.00 Y	144. 00
45.00 f costs for renal services are cl	aimed on Wkst A line 7	14 are the costs	: for		1. 00 N	2. 00 Y	145. 00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no i Llude Medicare utilization	n column 1. If c	column 1 is		IV.	'	143.0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	gy changed from the previ n column 1. (See CMS Pub.			lf	N		146. 0
						1.00	-
47.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			1.00 N	147. 0
48.00 Was there a change in the order of	allocation? Enter "Y" f	for yes or "N" fo	or no.			N	148. 0
49.00 Was there a change to the simplifi	ed cost finding method?	Enter "Y" for ye Part A	es or "N" f Part B		itle V	N Title XIX	149. 0
		1.00	2.00		3. 00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "		onent for Part A	and Part E		2 CFR §413	3. 13)	
55.00 Hospital 56.00 Subprovider - IPF		N N	N N		N N	N N	155. 0 156. 0
57. 00 Subprovi der – IRF		N	N		N	N	157. 0
58. 00 SUBPROVI DER		N	, N		N	N.	158. 0
59.00 SNF 60.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 0 160. 0
61. 00 CMHC			N		N	N	161. 0
Mul +i compus						1.00	
Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has o	one or more campu	ses in dif	ferent CB	SAs?	N	165. 0
	Name	County		Zip Code	CBSA	FTE/Campus	
66.00 If line 165 is yes, for each	0	1. 00	2. 00	3. 00	4.00	5.00	0 166. 0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						0.0	
column 5 (see instructions)							
[1. 1.1. 1. n. 1.	() incentive in the Ameri	can Recovery and	Reinvestm	ent Act		1.00	
Health Information Technology (UIT	7 Incentive III the Alleri			ICITE ACE		V	- 167. 0
68.00 f this provider is a CAH (line 10	05 is "Y") and is a meani	ngful user (line		"), enter	the	Y	
Health Information Technology (HIT 67.00 sthis provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	05 is "Y") and is a meani HT assets (see instructi not a meaningful user, do	ngful user (line ons) bes this provider	e 167 is "Y qualify f	or a hard		Y	168. 0

Health Financial Systems	PARIS COMMUNIT	Y HOSPITAL	In Lie	eu of Form CMS-2552-	
HOSPITAL AND HOSPITAL HEALT	H CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1320	Peri od:	Worksheet S-2	
			From 01/01/2023		
			To 12/31/2023		
				5/23/2024 4:0	1 pm
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 ar period respectively (170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", c	loes this provider have any days for ind	ividuals enrolled in	N	(171. 00
section 1876 Medicare					
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section					
1876 Medicare days in	column 2. (see instructions)				

	Financial Systems PARIS COMMUNI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 14-1320	Peri od:	eu of Form CMS- Worksheet S-2	
J. 1 1	THE THE THE TENETH STATE RETAINSONSEMENT GOESTI STATE	THOUSE C	75 11 1020	From 01/01/2023 To 12/31/2023	Part II Date/Time Pro	epare
				Y/N	5/23/2024 4:0 Date	D'I pm
				1. 00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NO TO	esponses. Ente	er all dates in	tne	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c		instructions)			1
			1.00	2. 00	V/I 3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N N	2.00	3.00	2
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3
	Teratronships: (See Tristructrons)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	N N	С		2
00	those on the filed financial statements? If yes, submit rec		IN IN			'
	,			Y/N	Legal Oper.	
	T			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	s the provider	- N		- 6
00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7
00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		o o	N N		8
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program in itiated of	is.		N		10
00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		1
	Teaching Program on Worksheet A? If yes, see instructions.				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 period? If yes, submit copy.			ost reporting	Y N	1.
00	If line 12 is yes, were patient deductibles and/or coinsural instructions.	ance amounts wa	aived? If yes,	see	N	1
00	Bed Complement Did total beds available change from the prior cost reporti	ng period2 lf	Vas soo inst	ructions	N	1!
00	Total beus avairable change from the pirol cost reporti		<u>yes, see mst</u> rt A		rt B	13
		Y/N	Date	Y/N	Date	
	locan o	1. 00	2.00	3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	04/12/2024	N		10
00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	'	04/12/2024	IV		'
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		Y	04/12/2024	11
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19

Heal th	Financial Systems PARIS COMMUNI	TY HOSPITAL		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1320	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/23/2024 4	repared:
			i pti on	Y/N	Y/N	
	1011 11 1000		0	1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	Thopas C data for other Population and action and action to	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 H	IOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases enterollifyes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the	e cost reportir	ng period? If	yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit el period? If yes, see instructions.	ntered into dur	ing the cost	reporti ng	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or		ebt Service R	eserve 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 mate		debt? If yes	, see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without i:	, see	N	31. 00		
	instructions.					
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	rvi ces furni she	ed through co	ntractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		na to competi	tive bidding? If	N	33. 00
	no, see instructions.	p	.gp			
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an a	arrangement wit	h provider-h	ased physicians?	Y	34.00
34.00	If yes, see instructions.	arrangement wr	ii provider t	asca priysi ci aris:	'	34.00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. 00
				Y/N	Date	
	ll 055' 0 1			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
37. 00	If line 36 is yes, has a home office cost statement been pullf yes, see instructions.	repared by the	home office?			37. 00
38. 00	If line 36 is yes , was the fiscal year end of the home of			N N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end of the provider render services to other than the provider render services to other than the provider render services to other than the provider render services.			, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
	That detrois.			_		
	Cost Report Preparer Contact Information	1.00 2.				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SHAWN		ADAMS		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	BLUE AND COMPA	ιΝΥ			42.00
	preparer.			CADAMO SI USTU	00.004	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508		SADAMS@BLUEAND	CO. COM	43. 00

Heal th	Financial Systems PARIS COMMUN	ITY HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1320	Peri od: From 01/01/2023	Worksheet S-2 Part II			
			To 12/31/2023		pared: 1 pm		
		2.00					
		3.00					
	Cost Report Preparer Contact Information				1		
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,						
	respectively.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.				12.00		
	Enter the telephone number and email address of the cost				43. 00		
					43.00		
	report preparer in columns 1 and 2, respectively.		1		I		

 Heal th Financial
 Systems
 PARIS C

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | | Prepared: | To 12/31/2023 | Date/Time Prepared: | Prepar Provider CCN: 14-1320

				1	0 12/31/2023	5/23/2024 4:0	
						I/P Days / 0/P	ı pili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	oompono	Li ne No.	0. 2003	Avai I abl e	or any recent riods of		
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	48, 192. 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 I PF Subprovi der						3. 00
4.00	HMO IRF Subprovider					o	4. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		25	9, 125	48, 192. 00	0	6. 00 7. 00
7.00	beds) (see instructions)		25	7, 123	46, 192.00	١	7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 125	48, 192. 00	0	14.00
15. 00	CAH visits					0	15.00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19. 00 20. 00	SKILLED NURSING FACILITY						19. 00 20. 00
21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02				0	26. 02
26. 03	RURAL HEALTH CLINIC IV	88. 03				0	26. 03
26. 04	RURAL HEALTH CLINIC V	88. 04				0	26. 04
26. 05	RURAL HEALTH CLINIC VI	88. 05				0	26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		25				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00 30. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 00	Total ancillary labor & delivery room						32. 00
52.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34. 00

Provider CCN: 14-1320

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/23/2024 4:01 pm

Total Will Title Will Title Will Title Will Total All Total All Total All Total Tota							5/23/2024 4: 0	1 pm
PART I - STATISTICAL DATA			I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Part - STATISTICAL DATA		C	T: +1 - W// 1 1	T: +1 - VIV	T-+-1 All	Takal lakaasa	F1 0	
PART I - STATISTICAL DATA 1.00 10.00 7.00 8.00 9.00 10.00		Component	little XVIII	little XIX				
PART I - STATISTICAL DATA			6.00	7 00				
1.00		PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see Instructions for col. 2 for the portion of LDP room available beds) 2.00	1.00		1, 182	9	2, 008			1.00
For the portion of LIDP room available beds) 2.00 0.00 3.00 3.00 4M0 IPF Subprovider					·			
2.00 MMO and other (see instructions) 286 126		Hospice days) (see instructions for col. 2						
3.00 HMO PF Subprovi der								
4.00 HMO IRF Subprovider		1	1					•
5.00 Hospital Adults & Peds. Swing Bed SNF 0			1					
6.00 Hospital Adults & Peds. Swing Bed NF 1,388 9 3,390			۱ ۱	-				1
Total Adults and Peds. (exclude observation beds) (see instructions) B.00 INTENSIVE CARE UNIT		, ,	200					•
Bods (See Instructions		, .	1 388	9				
S. 00	7.00		1, 500	,	3,370			7.00
10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 12. 00 12. 00 12. 00 12. 00 13. 00 12. 00 14. 00 15. 00 12. 00 13. 00 14. 00 14. 00 14. 00 14. 00 14. 00 15. 00 13. 00 14. 00 15. 00 15. 00 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 15. 00 15. 10 1	8.00							8. 00
11.00 SUBGICAL INTENSIVE CARE UNIT	9.00	CORONARY CARE UNIT						9. 00
12.00 NURSERY 12.00 NURSERY 13.00 14.00 10.10 15.00 NURSERY 15.00 16.00 16.00 16.00 15.00 16.00	10.00	BURN INTENSIVE CARE UNIT						10.00
13.00 NURSERY 13.00 NURSERY 14.00 Total (see instructions) 1,388 9 3,390 0.00 487.97 14.00 15.00 CAH visits 0 0 0 0 0 0 0 15.00 CAH visits 15.00 CAH visits 15.00 0 0 0 0 0 0 0 0 0		1						•
14.00 Total (see instructions) 1,388 9 3,390 0.00 487.97 14.00 15.00 CAH visits 0 0 0 0 0 15.10 REH hours and visits 0 0 0 0 16.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IPF 17.00 18.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVIDER 18.00 19.00 SAILLED NURSING FACILITY 19.00 20.00 OTHER LONG TERM CARE 21.00 21.00 OTHER LONG TERM CARE 22.00 22.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 24.00 HOSPICE (non-distinct part) 24.00 25.00 CMMC - CMMC 24.00 26.01 RURAL HEALTH CLINIC 11 435 0 3,942 0.00 26.02 RURAL HEALTH CLINIC 11 435 0 3,942 0.00 26.03 RURAL HEALTH CLINIC 11 455 0 1,940 0.00 3.90 26.02 26.04 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.03 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.04 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.05 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.06 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.07 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.08 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.09 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.01 RURAL HEALTH CLINIC 1 435 0 3,942 0.00 6.45 26.01 26.02 RURAL HEALTH CLINIC 1 455 0 1,940 0.00 3.90 26.02 26.03 RURAL HEALTH CLINIC 0 628 0 6,767 0.00 5.40 26.04 26.05 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 26.05 RURAL HEALTH CLINIC 0 0 0 0 0 0 27.00 Ambulance Trips 0 0 0 0 0 0 30.00 Employee di scount days (see instructions) 0 0 0 0 0 30.00 Employee di scount days (see instructions) 0 0 0 0 0 30.00 Total ancillary labor & delivery room outpatient days (see instructions) 30.00 0 0 0 0 0								l .
15.00 CAH visits CAH visi		4						ł
15. 10 REH hours and visits 0 0 0 0 0 15. 10			1, 388	9		0.00	487. 97	1
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 22. 00 HOSPI CE 24. 10 HOSPI CE (non-di stinct part) 25. 00 CoMHC - CMHC 26. 00 RURAL HEALTH CLINIC I I 435 0 0 3,942 0.00 6.45 26.01 26.02 RURAL HEALTH CLINIC I I 435 0 1,940 0.00 3.90 26.02 26.03 RURAL HEALTH CLINIC I I 455 0 1,940 0.00 3.90 26.02 26.03 RURAL HEALTH CLINIC IV 2,839 0 20,407 0.00 23.08 26.03 26.04 RURAL HEALTH CLINIC V 628 0 6,767 0.00 23.08 26.03 26.04 RURAL HEALTH CLINIC V 628 0 6,767 0.00 5.40 26.05 RURAL HEALTH CLINIC V 628 0 0 0.00 0.00 0.00 26.05 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 0.00 26.05 26.04 26.04 RURAL HEALTH CLINIC V 0 0 0 0 0.00 0.00 26.05 26.04 26.		4	0	-	· -			
17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 20. 00			U	U	0			1
18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 20. 00 ON UNESI NG FACILITY 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00		1						1
19. 00		1						
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 11		4						1
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 24.00 40.00 40.00 24.00 25.00 24.00 25.00 26.	20.00	NURSING FACILITY						20. 00
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 23. 00 24. 00 HOSPICE								1
24. 00								1
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 RURAL HEALTH CLINIC 26. 01 RURAL HEALTH CLINIC II 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC IV 27. 00 CMMC CMMC CMMC CMMC CMMC CMMC CMMC		1						
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC IV 27. 839 28. 00 20, 407 29. 00 00 00 00 00 00 00 00 00 00 00 00 00								ł
26. 00 RURAL HEALTH CLINIC 1 11, 392 0 47, 801 0.00 89. 13 26. 00 26. 01 RURAL HEALTH CLINIC II 435 0 3, 942 0.00 6. 45 26. 01 26. 02 RURAL HEALTH CLINIC III 455 0 1, 940 0.00 3. 90 26. 02 26. 03 RURAL HEALTH CLINIC IV 2, 839 0 20, 407 0.00 23. 08 26. 03 RURAL HEALTH CLINIC V 628 0 6, 767 0.00 5. 40 26. 04 26. 05 RURAL HEALTH CLINIC V 0 0 0 0.00 0.00 0.00 26. 05 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 615. 93 27. 00 28. 00 Observation Bed Days 9.00 Ambul ance Trips 0 0.00 Employee discount days (see instruction) 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 0 0 0 0 0 0 0.00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 33. 01 LTCH site neutral days and discharges 0 0 47, 801 0.00 4. 47, 801 0.00 6. 45 26. 01 3. 942 0.00 0.00 6. 45 26. 01 3. 942 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.					U			1
26. 01 RURAL HEALTH CLINIC III			11 302	0	/7 <u>8</u> ∩1	0.00	90 12	
26. 02 RURAL HEALTH CLINIC III				-				ł
26. 03 RURAL HEALTH CLINIC IV 2, 839 0 20, 407 0. 00 23. 08 26. 04 RURAL HEALTH CLINIC V 628 0 6, 767 0. 00 5. 40 26. 04 26. 05 RURAL HEALTH CLINIC VI 0 0 0 0 0. 00 0.								1
26. 05 RURAL HEALTH CLINIC VI 0 0 0 0 0 0.00 0.00 26. 05 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 0 1, 704 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 03		2, 839	0			23. 08	26. 03
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 615. 93 27. 00 28. 00 Observation Bed Days 19 1, 704 28. 00 29. 00 Ambulance Trips 0 Employee discount days (see instruction) Employee discount days - IRF 0 31. 00 29. 00	26.04	RURAL HEALTH CLINIC V	628	0	6, 767	0.00	5. 40	26. 04
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) Employee discount days - IRF 20.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 31.00 LTCH site neutral days and discharges 0.00 615.93 27.00 28.00 29.00 29.00 29.00 30.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.05	RURAL HEALTH CLINIC VI	0	0	0	0.00	0.00	26. 05
28.00 Observation Bed Days 19 1,704 28.00 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 33.00 LTCH non-covered days 0 33.00 LTCH site neutral days and discharges 0 33.01 1,704 28.00 29.00 29.00 29.00 30.00 3		FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			1
29.00 Ambulance 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 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 32.01 33.00 LTCH non-covered days 0 0 33.01 LTCH site neutral days and discharges 0 33.01							615. 93	•
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 1. TCH non-covered days 1. TCH site neutral days and discharges 0 33.00 33.01			_	19	1, 704			1
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 O O O O O O O O O O O O O O O O O O			0					
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								•
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01			0	0				
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01			١	U				1
33.00 LTCH non-covered days 0 33.00 LTCH site neutral days and discharges 0 33.01	52. 01				ĺ] 52.01
	33.00		0					33. 00
34.00 Temporary Expansion COVID-19 PHE Acute Care 0 0 0 0 34.00			0					33. 01
	34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Health Financial Systems PARIS OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1320

				10	12/31/2023	5/23/2024 4: 0	
		Full Time		Di sch	arges		
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	DART I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and		0	414	3	607	1. 00
1.00	8 exclude Swing Bed, Observation Bed and		U	414	٥	007	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			66	43		2. 00
3.00	HMO IPF Subprovider				O		3. 00
4.00	HMO IRF Subprovider				o		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0. 00	0	414	2	607	13.00
14. 00 15. 00	Total (see instructions) CAH visits	0.00	U	414	3	007	14. 00 15. 00
15. 10	REH hours and visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00 26. 00	CMHC - CMHC	0.00					25. 00
26. 00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	0. 00 0. 00					26. 00 26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 01
26. 03	RURAL HEALTH CLINIC IV	0.00					26. 03
26. 04	RURAL HEALTH CLINIC V	0. 00					26. 04
26. 05	RURAL HEALTH CLINIC VI	0. 00					26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 00
	Temporary Expansion COVID-19 PHE Acute Care						34. 00
	, , , , , , , , , , , , , , , , , , ,	1		1	'	'	

Health Financial Systems PARIS COMMUNITY HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

PROVIDENCE CONTROL OF FORM CMS-2552-10

Provider CCN: 14-1320

Period: From 01/01/2023

1103111	INSTITUTE RENAL DIALISIS DEFARIMENT STATISTICAL DATA			Frovider C	F	rom 01/01/2023	worksneet 3-5	
					Т	o 12/31/2023	Date/Time Prep 5/23/2024 4:0	
		0utpa	ti ent	Trai	ni ng	Home	372372024 4.0	ı pııı
		Regul ar	High Flux	Hemodi al ysi s	CAPD / CCPD	Hemodi al ysi s	CAPD / CCPD	
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
1. 00	Number of patients in program at end of cost reporting	12	0	0	0	0	0	1. 00
2. 00	period Number of times per week patient receives dialysis	3. 00	0. 00	0. 00	0.00	0.00	0. 00	2. 00
3. 00	Average patient dialysis time including setup	3. 50	0. 00	0. 00	0.00			3. 00
4. 00 5. 00	CAPD exchanges per day Number of days in year dialysis furnished	156	0		0.00		0.00	4. 00 5. 00
6. 00 7. 00	Number of stations Treatment capacity per day per station	8 1	O O	0	0			6. 00 7. 00
8. 00 9. 00	Utilization (see instructions) Average times dialyzers re-used	60. 74 0. 00	0. 00 0. 00					8. 00 9. 00
10. 00	4	0. 00	0. 00					10. 00
							Y/N 1.00	
10. 01	ESRD PPS Is the dialysis facility appro-	ved as a low-vo	olume facility	for this cost	reporting peri	od? Enter "Y"	N	10. 01
10. 02	for yes or "N" for no. (see in: Did your facility elect 100% Pl	PS effective Ja	nuary 1, 2011?	Enter "Y" for	yes or "N" fo	r no. (See	Y	10. 02
	instructions for "new" provide	15.)				Prior to 1/1 1.00	After 12/31 2.00	
10. 03	If you responded "N" to line 10 periods prior to January 1 and after December 31. (see instruc	enter in colum				0		10. 03
11 00	TRANSPLANT INFORMATION	at list				0	I	11. 00
	Number of patients on transplanted Number of patients transplanted EPOETIN		ost reporting p	eri od		0		12.00
13.00	Net costs of Epoetin furnished	to all mainter	ance di al ysi s	patients by th	e provi der.			13. 00
	Epoetin amount from Worksheet							14. 00
	Number of EPO units furnished Number of EPO units furnished ARANESP							15. 00 16. 00
17. 00	Net costs of ARANESP furnished	to all mainter	nance di al ysi s	patients by th	e provi der.			17. 00
	ARANESP amount from Worksheet							18. 00
	Number of ARANESP units furnish							19.00
20.00	Number of ARANESP units furnis	ned relating to	the nome diai	ysis departmen	It .	MCP	INITIAL METHOD	20. 00
						1. 00	2.00	
	PHYSICIAN PAYMENT METHOD							
21. 00	Enter "X" if method(s) is appl		uni n+i on	Not Coot of	Not Coot of	Number of ECA	X Number of ECA	21. 00
		ESA Desc			Net Cost of ESAs for Home		Units - Home	
		1.	00	Pati ents 2.00	Patients 3.00	4. 00	Dialysis Dept. 5.00	
	ESAs							
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program.			0	0	0	0	22. 00
	(see instructions)							

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		Peri od: From 01/01/2023	Worksheet S-5	
			Date/Time Pre 5/23/2024 4:0	
		CCN	Treatments	
		1. 00	2. 00	
23.00 If line 10.01 is yes, enter in column 1 the CC listed on Worksheet S-2, Part I, line 18, and total treatments for each CCN. (see instruction	its subscripts. Enter in column 2, the		0	23. 00

	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1320	Peri od:	Worksheet		2552-
	LE BROLD WING, LENG CHAIL CHAIL BROWN				From 01/01/202	3		
			Component	CCN: 14-3987	To 12/31/202	3 Date/Time 5/23/2024		
					RHC I	Cos		ı pııı
						00		
(Clinic Address and Identification					. 00		
	Street				727 EAST COUR	T_STREET		1. 0
				ty	State	ZIP Code		
				00	2. 00	3.00		
00	City, State, ZIP Code, County		PARI S			L 61944		2. (
						1.00		
00 I	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for ۱				0	3. (
					nt Award	Date		
c	Source of Federal Funds				1. 00	2.00		
	Community Health Center (Section 330(d), PHS	Act)						4. 0
	Migrant Health Center (Section 329(d), PHS Ac							5. 0
- 1	Health Services for the Homeless (Section 340	,						6.
00 /	Appalachian Regional Commission							7.
	Look-Alikes							8.
	OTHER (SPECIFY)							9.
)1								9.
)2								9.
03								9. 9.
05								9.
06								9.
07								9.
80								9.
09								9.
10								9.
					1. 00	2.00		
	Does this facility operate as other than a ho				N		0	10.
	yes or "N" for no in column 1. If yes, indica							
	2. (Enter in subscripts of line 11 the type of hours.)	other operati	on(s) and the	operating				
	Hours.)	Sund	day	М	onday	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	Facility bayes of anamatiana (1)				1 00	loo oo		
	Facility hours of operations (1)			00.00			- 1	
	CLINIC			08: 00	17: 00	08: 00		11.
	, , ,			08: 00	1.00	2. 00		11.
. 00	CLINIC Have you received an approval for an exception			ard?	1. 00 N			12.
. 00	CLINIC Have you received an approval for an exception is this a consolidated cost report as defined	d in CMS Pub. 1	00-04, chaptei	ard? - 9, section	1. 00		0	12.
00	CLINIC Have you received an approval for an exception Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column	d in CMS Pub. 1 umn 1. If yes,	00-04, chaptei enter in colur	ard? ~ 9, section nn 2 the	1. 00 N		0	12.
00 (00 00	Have you received an approval for an exception 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.	d in CMS Pub. 1 umn 1. If yes,	00-04, chaptei enter in colur	ard? ~ 9, section nn 2 the	1. 00 N		0	12.
00 00 00 1	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapter enter in colur of all provid	ard? - 9, section nn 2 the ders and	1. 00 N N			12. 13.
. 00	Have you received an approval for an exception 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. If line 13, column 1, is "Y", are you reporti	d in CMS Pub. 1 umn 1. If yes, List the names ng multiple co	00-04, chapter enter in colur of all provid	ard? - 9, section nn 2 the ders and Cs (as defined	1. 00 N N			12. 13.
. 00 (Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes, List the names ng multiple co)? Enter "Y" f	00-04, chapterenter in columenter in columen	ard? - 9, section nn 2 the ders and Cs (as defined for no. If	1. 00 N N			12. 13.
. 00 (Have you received an approval for an exception of this aconsolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated separate Worksheet S-8 for each consolidated	d in CMS Pub. 1 Jumn 1. If yes, List the names In multiple co Program of the control of the control RHC grouping.	00-04, chapter enter in colur of all provides a solidated RHG or yes or "N" ings and complicated	ard? - 9, section nn 2 the ders and Cs (as defined for no. If ete a RHC groupings	1.00 N N			12. 13.
. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 1 Jumn 1. If yes, List the names Ing multiple co Property of the control of the control RHC grouping. Consolidated RHC	00-04, chapter enter in colur of all provides all provides and complete and complete and consolidated sin the group	ard? - 9, section nn 2 the ders and Cs (as defined for no. If ete a RHC groupings	1.00 N N			12. 13.
. 00 [Have you received an approval for an exception of this aconsolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated separate Worksheet S-8 for each consolidated	d in CMS Pub. 1 Jumn 1. If yes, List the names Ing multiple co Property of the control of the control RHC grouping. Consolidated RHC	00-04, chapter enter in colur of all provides all provides and complete and complete and consolidated sin the group	ard? 7 9, section mn 2 the ders and Cs (as defined for no. If ete a RHC groupings on or	1.00 N N	2.00		12. 13.
2. 00 (1 2. 00 (1 3. 00 (1 3. 01 (1 3. 01 (1)	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 1 Jumn 1. If yes, List the names Ing multiple co Property of the control of the control RHC grouping. Consolidated RHC	00-04, chapter enter in colur of all provides all provides and complete and complete and consolidated sin the group	ard? - 9, section nn 2 the ders and Cs (as defined for no. If ete a RHC groupings oing or	1.00 N N			12. 13. 13.

Health Financial Systems	P.	PARIS COMMUNI	TY_HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL	_ DATA		Provider Co	CN: 14-1320	Peri od:	Worksheet S-8	
			Component	CCN: 14-3987	From 01/01/2023 To 12/31/2023		
					RHC I	Cost	
		Y/N	V	XVIII	XIX	Total Visits	
		1. 00	2. 00	3.00	4. 00	5. 00	
15.00 Have you provided all or sub GME cost? Enter "Y" for yes column 1. If yes, enter in c 4 the number of program visi Intern & Residents for title XIX, as applicable. Enter in number of total visits for t (see instructions)	or "N" for no in columns 2, 3 and ts performed by s V, XVIII, and column 5 the			nty 00			15.00
2.00 City, State, ZIP Code, Count	У		EDGAR				2. 00
		Tuesday	Wedne	esday	Thur	sday	
		to	from	to	from	to	
		6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations							
11. 00 CLI NI C	17:		08: 00	19: 00		19: 00	11. 00
		Fri	day	Sa	turday		
		from	to	from	to		
		11. 00	12. 00	13. 00	14. 00		
Facility hours of operations							
11. 00 CLI NI C	08:	: 00	19: 00	08: 00	11: 30		11. 00

Health Fi	nancial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	eu of Form Cl	MS-2	552-10
HOSPI TAL-	-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1320	Peri od:	Worksheet	S-8	
			Component	CCN: 14-3989	From 01/01/2023 To 12/31/2023	Date/Ti me 5/23/2024		
					RHC II	Cos		
					1	00		
CL	inic Address and Identification					00		
	treet				144 ILLINOIS			1. 00
				ty	State	ZIP Code		
2. 00 Ci	ty, State, ZIP Code, County	(T. CHRI SMAN	00	2. 00	3. 00 61924		2. 00
2.00 01	ty, state, 211 sode, sounty	I`	OTHER CHILLIA			01721		2.00
0.00 110	2001711 01050 5010 01111 0					1. 00		
3.00 HO	OSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	l or "U" for ι		t Award	Date	0	3. 00
					1. 00	2.00		
	ource of Federal Funds							
1	ommunity Health Center (Section 330(d), PHS							4. 00
1	grant Health Center (Section 329(d), PHS A ealth Services for the Homeless (Section 34)							5. 00 6. 00
1	opalachian Regional Commission	o(a), ind Act)						7. 00
	ook-Alikes							8. 00
	THER (SPECIFY)							9.00
9. 01								9. 01
9. 02								9. 02 9. 03
9. 03 9. 04								9. 03
9. 05								9. 05
9. 06								9. 06
9. 07								9. 07
9. 08								9. 08
9. 09 9. 10								9. 09 9. 10
9. 10								9. 10
					1. 00	2. 00		
	pes this facility operate as other than a ho es or "N" for no in column 1. If yes, indica				N		0	10. 00
	(Enter in subscripts of line 11 the type o							
	ours.)							
		Sund			onday .	Tuesday		
		1.00	2. 00	from 3.00	4. 00	from 5.00		
Far	cility hours of operations (1)	1.00	2.00	3.00	4.00	3.00		
11. 00 CL				08: 00	12: 00	13: 30		11. 00
					1.00	2.00		
					1. 00	2. 00		
12 00 Ha	ave you received an approval for an exception	on to the produc	ctivity standa	rd2	N			12 00
	ave you received an approval for an exceptions this a consolidated cost report as define				N N		0	
13.00 Is	ave you received an approval for an exceptions this a consolidated cost report as defined 0.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. 1	00-04, chapter	9, section	N N		0	
13. 00 Is 30 nu	s this a consolidated cost report as defined D.8? Enter "Y" for yes or "N" for no in coll umber of providers included in this report.	d in CMS Pub. 10 umn 1. If yes,	00-04, chapter enter in colum	9, section nn 2 the			0	
13. 00 I s 30 nu nu	s this a consolidated cost report as defined D.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Umbers below.	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapter enter in colum of all provic	9, section nn 2 the ders and	N			13. 00
13. 00 Is 30 nu nu 13. 01 If	s this a consolidated cost report as defined).8? Enter "Y" for yes or "N" for no in columber of providers included in this report. umbers below. If line 13, column 1, is "Y", are you report.	d in CMS Pub. 10 umn 1. If yes, List the names ing multiple co	00-04, chapter enter in colum of all provic	9, section nn 2 the ders and Cs (as defined	N			13. 00
13. 00 Is 30 nu nu 13. 01 If in ye	s this a consolidated cost report as defined 0.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Imbers below. In this is "Y", are you report of the column 1, is "Y", are you report of the column 1, is "Y", are you report of the column 2, the number of consolices, enter in column 2 the number of consolices.	d in CMS Pub. 19 umn 1. If yes, of List the names ing multiple co)? Enter "Y" for dated RHC group	00-04, chapter enter in colum of all provic nsolidated RHC or yes or "N" ings and compl	9, section on 2 the ders and Cs (as defined for no. If ete a	N N			13. 00
13. 00 Is 30 nu nu 13. 01 If in ye se	s this a consolidated cost report as defined 0.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Imbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 es, enter in column 2 the number of consolideparate Worksheet S-8 for each consolidated	d in CMS Pub. 10 umn 1. If yes, List the names ing multiple co)? Enter "Y" for dated RHC group RHC grouping.	00-04, chapter enter in colum of all provic nsolidated RHC or yes or "N" ings and compl Consolidated	9, section nn 2 the ders and Cs (as defined for no. If ete a RHC groupings	N N			12. 00 13. 00
13. 00 Is 30 nu nu 13. 01 If in ye se ar	s this a consolidated cost report as defined 0.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Included in this report. Included in this report. Included in this report. In cMS Pub. 100-02, chapter 13, section 80.2 pes, enter in column 2 the number of consolidated re comprised exclusively of grandfathered compositions.	d in CMS Pub. 10 umn 1. If yes, List the names ing multiple co)? Enter "Y" fo dated RHC group RHC grouping. pnsolidated RHC	00-04, chapter enter in colum of all provice nsolidated RHC or yes or "N" ings and compl Consolidated s in the group	9, section nn 2 the ders and Cs (as defined for no. If ete a RHC groupings	N N			13. 00
13. 00 Is 30 nu nu 13. 01 If in ye se ar	s this a consolidated cost report as defined 0.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Imbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 es, enter in column 2 the number of consolideparate Worksheet S-8 for each consolidated	d in CMS Pub. 10 umn 1. If yes, List the names ing multiple co)? Enter "Y" fo dated RHC group RHC grouping. pnsolidated RHC	00-04, chapter enter in colum of all provice nsolidated RHC or yes or "N" ings and compl Consolidated s in the group	9, section nn 2 the ders and Cs (as defined for no. If ete a RHC groupings ping or	N N	CCN		13. 00
13. 00 Is 30 nu nu 13. 01 If in ye se ar	s this a consolidated cost report as defined 0.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Included in this report. Included in this report. Included in this report. In cMS Pub. 100-02, chapter 13, section 80.2 pes, enter in column 2 the number of consolidated re comprised exclusively of grandfathered compositions.	d in CMS Pub. 10 umn 1. If yes, List the names ing multiple co)? Enter "Y" fo dated RHC group RHC grouping. pnsolidated RHC	00-04, chapter enter in colum of all provice nsolidated RHC or yes or "N" ings and compl Consolidated s in the group	9, section nn 2 the ders and Cs (as defined for no. If ete a RHC groupings oing or Provi	N N	CCN 2. 00		13. 00

Health Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	In Lieu of Form CMS-2552-1			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 14-1320	Peri od:	Worksheet S-8			
		Component (CCN: 14-3989	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0			
				RHC II	Cost			
	Y/N	V	XVIII	XI X	Total Visits			
	1.00	2.00	3.00	4. 00	5. 00			
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 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)		Cou	ntv			15. 00		
			00					
2.00 City, State, ZIP Code, County		EDGAR				2. 00		
	Tuesday	Wedne	esday	Thur	sday			
	to	from	to	from	to			
	6.00	7.00	8. 00	9. 00	10.00			
Facility hours of operations (1)								
11. 00 CLINIC	19: 30			08: 00	12: 00	11. 00		
	Fri	day	Sa	turday				
	from	to	from	to				
	11. 00	12.00	13. 00	14. 00				
Facility hours of operations (1)						1		
11. 00 CLI NI C	08: 00	12: 00				11. 00		

Heal th	n Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	u of Form CMS	-2552-1
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 14-1320	Peri od: From 01/01/2023	Worksheet S-	8
			Component	CCN: 14-8596	To 12/31/2023	Date/Time Pr 5/23/2024 4:	
					RHC III	Cost	01 piii
					1.	00	
	Clinic Address and Identification				1.	00	
1.00	Street				721 EAST COURT		1. 00
			Ci 1.		State 2.00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		PARI S	00		61944	2.00
						4.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	r "R" for rura	ıl or "II" for u	rhan		1. 00	3.00
0.00	THOSE THE BROCK FRIOS ONET. Best graction Effect	n it for fara	01 0 101 0		nt Award	Date	0.00
					1.00	2. 00	
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Ac+)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac						5.00
6.00	Health Services for the Homeless (Section 340						6. 00
7.00	Appal achi an Regional Commission						7. 0
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						9. 0
7.00	OTIEK (SI EGITT)						7. 00
					1. 00	2. 00	
10. 00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of	ite number of a	ther operation	s in column	N	(10.00
	hours.)	Sun	dav	N	Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.00
11.00	oerm o			00.00	17.00	00.00	11.00
					1. 00	2. 00	
12. 00 13. 00	1 3 11				N N		12. 00 13. 00
13.00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.	ımn 1. If yes,	enter in colum	n 2 the	N	'	13.00
13. 01	If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.2) yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC	? Enter "Y" f lated RHC group RHC grouping. onsolidated RHC	For yes or "N" bings and compl Consolidated Es in the group	for no. If ete a RHC grouping		,	13. 0
		 		Prov	ider name	CCN	
14 00	DUC/FOUC name CCN				1. 00	2. 00	14.00
14. 00	RHC/FQHC name, 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 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)						15. 00

Health Financial Systems	PARIS COMMUNI	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-1320	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8596	From 01/01/2023 To 12/31/2023		
				RHC III	Cost	
		Со	unty			
		4	. 00			
2.00 City, State, ZIP Code, County		EDGAR				2. 00
	Tuesday	Wedr	nesday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8.00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	19: 00	08: 00	19: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	19: 00	08: 00	11: 30		11. 00

Heal th	Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Li	eu of Form CMS	-2552-10
HOSPI ⁻	FAL-BASED RHC/FQHC STATISTICAL DATA		Provider Component	CN: 14-1320 CCN: 14-8607	Peri od: From 01/01/2023 To 12/31/2023		epared:
					RHC I V	Cost	
					1	. 00	
	Clinic Address and Identification					. 00	
1.00	Street				1 PHILLIPS LA		1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County		PARI S	00	2.00	3. 00 L 61944	2. 00
	janey, course, course, course,				,		
2.00	HOCDITAL DACED FOUCE ONLY Designation Fint	IIDII 6				1.00	0 2 00
3. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	er k for rura	ii or u toru		int Award	Date	0 3.00
				0. 4	1. 00	2.00	
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)					4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
					1.00	2.00	
10. 00	yes or "N" for no in column 1. If yes, indica 2.(Enter in subscripts of line 11 the type of	ate number of o	ther operation	s in column	1. 00 N	2.00	0 10.00
	hours.)	Sun	dav	1	Monday	Tuesday	
		from	to	from	to	from	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11. 00
11.00	CET WILC			00.00	17.00	00.00	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception 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. In numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section in 2 the	N N		12.00 0 13.00
13. 01	If line 13, column 1, is "Y", are you reportin CMS Pub. 100-02, chapter 13, section 80.2) yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHG)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC	for yes or "N" bings and compl Consolidated Es in the group	for no. If ete a RHC grouping			0 13. 01
	,			Prov	rider name	CCN	
14.00	DUC (FOLIC TOTAL COM				1. 00	2.00	14.00
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14. 00
		1.00	2.00	3. 00	4. 00	5. 00	<u> </u>
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15. 00

Health Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1320	Peri od:	Worksheet S-8	
				From 01/01/2023		
		Component	CCN: 14-8607	To 12/31/2023		
					5/23/2024 4: 0	т ріп
				RHC I V	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		EDGAR				2. 00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)				·		
11. 00 CLINIC	17: 00	08: 00	19: 00	08: 00	19: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	19: 00	08: 00	11: 30		11. 00

Financial Systems	PARIS COMMUNI		ON. 14 1000				2-1
AL-RASED KHC/FUHC STATISTICAL DATA		Provider C	JN: 14-1320			-8	
		Component	CCN: 14-8606		Date/Time Pi		
				DHC V			om
				INTO V			
				1.	00		
Clinic Address and Identification				1/00 NODTH H	1007 4	┥,	
Street		Ci	tv				1. 0
City, State, ZIP Code, County		MARSHALL				2	2. 0
HOSDITAL BASED FOHCE ONLY: Designation Ent	or "D" for rur	d or "II" for u	rhan		1.00	0 /	3. 0
THOSE THE BASED TUNES ONET. Designation - Little	er K TOLTULA	11 01 0 101 0		nt Award	Date		3. 0
				1. 00	2.00		
Source of Federal Funds			ı				
							4. 00 5. 00
							5. U 6. 0
Appal achi an Regional Commission	o(u) / 1110 /101)						7. 0
Look-Alikes							8. 0
OTHER (SPECIFY)						9	9. 0
				1 00	2 00		
Does this facility operate as other than a ho	ospi tal -based F	RHC or FQHC? En	ter "Y" for	N N	2.00	0 10	0. 0
	f other operati	on(s) and the	operati ng				
[nours.)	Sur	day	N	Monday	Tuesday		
	from	to	from	to	from		
			from 3.00	to 4.00	from 5.00		
Facility hours of operations (1)	from	to	3.00	4. 00	5. 00	1.	1 0
Facility hours of operations (1)	from	to				1-	1. 0
	from	to	3.00	4. 00	5. 00	11	1. 00
CLINIC Have you received an approval for an exception	from 1.00 on to the produ	to 2.00	3. 00 08: 00 rd?	4. 00 17: 00 1. 00 N	5. 00	12	2. 0
Have you received an approval for an exception is this a consolidated cost report as defined	from 1.00 on to the produ	to 2.00 activity standa 00-04, chapter	3.00 08:00 rd? 9, section	4. 00 17: 00 1. 00	5. 00	12	2. 0
Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	from 1.00 on to the product of the CMS Pub. cumn 1. If yes,	to 2.00 activity standa 00-04, chapter enter in colum	3.00 08:00 rd? 9, section in 2 the	4. 00 17: 00 1. 00 N	5. 00	12	2. 0
Have you received an approval for an exception is this a consolidated cost report as defined	from 1.00 on to the product of the CMS Pub. cumn 1. If yes,	to 2.00 activity standa 00-04, chapter enter in colum	3.00 08:00 rd? 9, section in 2 the	4. 00 17: 00 1. 00 N	5. 00	12	2. 0
Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you reporting the solution of the solution in the solution is the solution of the solution in the solution is the solution of the solution is the solution in the solution in the solution is the solution in the solution in the solution is the solution in the solution in the solution is the solution in the solution in the solution is the solution in the solution in the solution is the solution in the solution in the solution is the solution in the solution in the solution is the solution in the s	from 1.00 on to the production CMS Pub. fumn 1. If yes, List the names	to 2.00 activity standa 00-04, chapter enter in colum s of all provid	3.00 08:00 rd? 9, section n 2 the ers and s (as define	4. 00 17: 00 1. 00 N	5. 00	12	2. 00
Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you reporting CMS Pub. 100-02, chapter 13, section 80.2	from 1.00 on to the production CMS Pub. fumn 1. If yes, List the names fing multiple cc	to 2.00 activity standa 00-04, chapter enter in colum s of all provid onsolidated RHC for yes or "N"	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If	4. 00 17: 00 1. 00 N	5. 00	0 13	2. 00
Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2; yes, enter in column 2 the number of consolidations.	from 1.00 on to the product of the control of the product of the product of the control of the	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a	4. 00 17: 00 1. 00 N N	5. 00	0 13	2. 00
Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you reporting CMS Pub. 100-02, chapter 13, section 80.2	from 1.00 on to the product of in CMS Pub. umn 1. If yes, List the names ing multiple co)? Enter "Y" 1 dated RHC group RHC grouping.	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl Consolidated	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping	4. 00 17: 00 1. 00 N N	5. 00	0 13	2. 00
Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated	from 1.00 on to the product of the	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" ings and compl Consolidated cs in the group	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or	4. 00 17: 00 1. 00 N N	5. 00 08: 00 2. 00	0 13	2. 00
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Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report. In the second of the second in the second in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered consolidated consolidated are comprised exclusively of grandfathered consolidated consolida	from 1.00 on to the product of in CMS Pub. dumn 1. If yes, List the names ing multiple co)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl Consolidated s in the group bing.	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	4.00 17:00 1.00 N N N identification in the state of t	5. 00 08: 00 2. 00 CCN 2. 00 Total Visits	0 13	2. 0
Have you received an approval for an exception 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. In the second of the second in this report. In In this re	from 1.00 on to the product of the	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl Consolidated s in the group bing.	3.00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or	4.00 17:00 1.00 N N N id N	5. 00 08: 00 2. 00 CCN 2. 00	0 13	3. 0
Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column of providers included in this report. In the second of th	from 1.00 on to the product of in CMS Pub. Jumn 1. If yes, List the names ing multiple co ? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl Consolidated s in the group bing.	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	4.00 17:00 1.00 N N N identification in the state of t	5. 00 08: 00 2. 00 CCN 2. 00 Total Visits	0 13	2. 0 3. 0 3. 0
Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column of providers included in this report. In the second of providers included in this report. In the second of providers included in this report. In the second of providers included in this report. In the second of providers in column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of grandfathered comprised exclusively of new consolidated RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	from 1.00 on to the product of in CMS Pub. Jumn 1. If yes, List the names ing multiple co ? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl Consolidated s in the group bing.	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	4.00 17:00 1.00 N N N identification in the state of t	5. 00 08: 00 2. 00 CCN 2. 00 Total Visits	0 13	2. 0 3. 0 3. 0
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Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.22 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of grandfathered comprised exclusively of new consolidated RHC RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	from 1.00 on to the product of in CMS Pub. Jumn 1. If yes, List the names ing multiple co ? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl Consolidated s in the group bing.	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	4.00 17:00 1.00 N N N identification in the state of t	5. 00 08: 00 2. 00 CCN 2. 00 Total Visits	0 13	2. 00
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Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.22 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of grandfathered comprised exclusively of new consolidated RHC RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	from 1.00 on to the product of in CMS Pub. Jumn 1. If yes, List the names ing multiple co ? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 00-04, chapter enter in colum s of all provid consolidated RHC for yes or "N" bings and compl Consolidated s in the group bing.	3.00 08:00 rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	4.00 17:00 1.00 N N N identification in the state of t	5. 00 08: 00 2. 00 CCN 2. 00 Total Visits	0 13	2. C 3. C
	Clinic Address and Identification Street City, State, ZIP Code, County HOSPITAL-BASED FOHCS ONLY: Designation - Enter Source of Federal Funds Community Health Center (Section 330(d), PHS AMIGENT AND AMIGENT	Clinic Address and Identification Street City, State, ZIP Code, County HOSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rura Source of Federal Funds Community Health Center (Section 330(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Health Services for the Homeless (Section 340(d), PHS Act) Appalachian Regional Commission Look-Alikes OTHER (SPECIFY) Does this facility operate as other than a hospital-based F yes or "N" for no in column 1. If yes, indicate number of c 2. (Enter in subscripts of line 11 the type of other operatinours.)	Clinic Address and Identification Street Ci 1. City, State, ZIP Code, County MARSHALL HOSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for use the services for the Homeless (Section 330(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Appalachian Regional Commission Look-Alikes OTHER (SPECIFY) Does this facility operate as other than a hospital-based RHC or FOHC? Enters or "N" for no in column 1. If yes, indicate number of other operation 2. (Enter in subscripts of line 11 the type of other operation(s) and the	Clinic Address and Identification Street City 1.00 City, State, ZIP Code, County MARSHALL HOSPITAL-BASED FQHCS ONLY: Designation - Enter "R" for rural or "U" for urban Gra Source of Federal Funds Community Health Center (Section 330(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Health Services for the Homeless (Section 340(d), PHS Act) Appal achi an Regional Commission Look-Alikes OTHER (SPECIFY) Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column hours.)	AL-BASED RHC/FQHC STATISTICAL DATA Provider CCN: 14-1320 Period: From 01/01/2023 To 12/31/2023 RHC V Clinic Address and Identification Street I602 NORTH IL City State 1.00 2.00 City, State, ZIP Code, County MARSHALL IL HOSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for urban Grant Award 1.00 Source of Federal Funds S	AL-BASED RHC/FOHC STATISTICAL DATA Provider CCN: 14-1320 Component CCN: 14-8606 Component	AL-BASED RHC/FOHC STATISTICAL DATA Provider CCN: 14-1320 Component CCN: 14-8606 From 01/01/2023 To 12/31/2023 Date/Time Preparation of the provider CCN: 14-8606 To 12/31/2023 Date/Time Preparation of the provider CCN: 14-8606 To 12/31/2023 Date/Time Preparation of the provider CCN: 14-8606 To 12/31/2023 Date/Time Preparation of the provider CCN: 14-8606 To 12/31/2023 Date/Time Preparation of the provider CCN: 14-8606 To 12/31/2023 Date/Time Preparation of the provider CCN: 14-8606 To 0 To

Health Financial Systems	PARIS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-1320	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8606	From 01/01/2023 To 12/31/2023		
				RHC V	Cost	
		Со	unty			
		4	. 00			
2.00 City, State, ZIP Code, County		CLARK				2. 00
	Tuesday	Wedr	nesday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	19: 00	08: 00	19: 00	11. 00
	Fri	i day	Sa	iturday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	19: 00	08: 00	11: 30		11. 00

Heal th	Financial Systems	PARIS COMMUNI	TY_HOSPITAL		In Lie	eu of Form CMS	-2552-
HOSPI 1	AL-BASED RHC/FQHC STATISTICAL DATA		Provider Component (CN: 14-1320 CCN: 15-8573	Period: From 01/01/2023 To 12/31/2023	Date/Time Pr	repared
					RHC VI	5/23/2024 4: Cost	
					1	. 00	
	Clinic Address and Identification				1.	. 00	
1.00	Street				567 N ST		1.
			Ci		State	ZIP Code	
2.00	City, State, ZIP Code, County		TERRE HAUTE	00	2. 00	3. 00 47809	2.
2.00	crty, State, 211 code, codifty		TERRE HAUTE		11	47607	2.
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for u				0 3.
				Gra	nt Award 1.00	2. 00	_
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.
6. 00 7. 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	O(d), PHS Act)					6. 7.
8. 00	Look-Alikes						8.
9. 00	OTHER (SPECIFY)						9.
10. 00	Does this facility operate as other than a ho	enital bacad D	UC or FOUC2 En	tor "V" for	1. 00 N	2.00	0 10.
10.00	yes 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 operation	s in column	IN .		0 10.
	illour s.)	Sun	dav		Monday	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	16: 30	08: 00	11.
11.00	CELINIC			08.00	10. 30	08.00	11.
					1. 00	2.00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column approval below:	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section in 2 the	N		12. 0 13.
13. 01	numbers below. 101 If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.						
	, , , , , , , , , , , , , , , , , , , ,		- J	Prov	ider name	CCN	
	1				1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	\/ /N		2071.1.1	VIV	T-+-! \\(: \; - : +-	14.
		Y/N 1.00	2. 00	3. 00	XI X 4. 00	Total Visits)
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.

Health Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1320	Peri od:	Worksheet S-8	-
		Component	CCN: 15-8573	From 01/01/2023 To 12/31/2023		
		_		RHC VI	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		VI GO				2. 00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	16: 30	08: 00	16: 30	08: 00	16: 30	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)				· .		
11. 00 CLINIC	08: 00	16: 30				11. 00

	Financial Systems	PARIS COMMUNITY		11 1000		eu of Form CMS-2	
IOSPI TAI	L UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared
						5/23/2024 4:0	I pm
						1. 00	
_	PART I - HOSPITAL AND HOSPITAL COMPLEX						
	Incompensated and Indigent Care Cost-to						
	Cost to charge ratio (see instructions)					0. 523993	1. (
	Medicaid (see instructions for each lir	ne)				10 171 017	
	Net revenue from Medicaid	. 6 . 10				13, 171, 847	2. (
	Did you receive DSH or supplemental pay				. 10	Y	3. (
	If line 3 is yes, does line 2 include a			rom wedica	10?	, Y	4. (
	If line 4 is no, then enter DSH and/or Medicaid charges	suppremental payments i	rom wearcard			51, 215, 596	5. C
	Wedicald charges Medicald cost (line 1 times line 6)					26, 836, 614	7.0
	Difference between net revenue and cos	ts for Medicald program	(see instructi	ons)		13, 664, 767	
	Children's Health Insurance Program (Ch			0113)		13,004,707	0.0
	Net revenue from stand-alone CHIP	iii) (see iiisti deti olis i	or each trile)			0	9.0
	Stand-alone CHIP charges					0	
	Stand-alone CHIP cost (line 1 times li	ne 10)				0	
2.00	Difference between net revenue and cos	ts for stand-alone CHIP	(see instructi	ons)		0	12.0
	other state or local government indiger						ĺ
3.00	Net revenue from state or Local indige	nt care program (Not inc	luded on lines	2, 5 or 9)	0	13.0
	Charges for patients covered under sta	te or local indigent car	re program (Not	included	in lines 6 or	0	14. C
	10)					_	
	State or local indigent care program co			,		0	15. C
	Difference between net revenue and cos Grants, donations and total unreimburse					0	16.0
	nstructions for each line)	ed cost for medicald, cr	iiP and State/i	ocai marg	ent care prograi	iis (see	
	Private grants, donations, or endowmen	t income restricted to f	unding charity	, care		0	17. C
- 1	Government grants, appropriations or to					0	18. C
9.00 T	Total unreimbursed cost for Medicaid , B, 12 and 16)				(sum of lines	13, 664, 767	19. C
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col . 2)	
				1. 00	2. 00	3. 00	
	Uncompensated care cost (see instruction			1 710 01	7	1 740 047	20.5
	Charity care charges and uninsured disc Cost of patients approved for charity o			1, 710, 81			
	cost or patients approved for charity (instructions)	care and unitisured disco	Juits (see	896, 45		890, 456	Z 1. U
	Payments received from patients for amo	ounts previously writter	n off as		0	0	22.0
	charity care	cante proviously in the					
	Cost of charity care (see instructions))		896, 45	6 0	896, 456	23.0
						1.00	

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

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

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Medicare allowable bad debts (see instructions)

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

0 25.00

5, 243, 426

4, 828, 326

2, 675, 293

3, 571, 749

17, 236, 516 31. 00

269, 816

415, 100

25.01

26.00

27.00

27.01

28.00

29.00

30.00

25.00

25. 01

27.01

stay limit

Medicaid (see Instructions for each line) Net revenue From Medicaid Net revenue From Medicaid	S-2552-1
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio	l repared:
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio	
Incompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions) Medicaid (see instructions for each line)	
Cost to charge ratio (see instructions) Medicaid (see instructions for each line)	
Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?	1.0
Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges No.	
1	2.0
1 1 1 1 2 1 2 3 3 3 3 3 3 3 3 3	3.0
Medicaid charges Medicaid cost (line 1 times line 6) Medicaid cost (line 1 times line 10) Met revenue from stand-alone CHIP Stand-alone CHIP cost (line 1 times line 10) Met revenue from stand-alone CHIP cost (line 1 times line 10) Met revenue from state or local indigent care program (see instructions) Met revenue from state or local indigent care program (see instructions for each line) Met revenue from state or local indigent care program (Not included on lines 2, 5 or 9) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in lines 6 or 10) Met revenue from state or local indigent care program (Not included in line	4.0
Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (see instructions)	5.0
8.00 Difference between net revenue and costs for Medicaid program (see instructions)	6.0
Children's Health Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-al one CHIP Stand-al one CHIP cost (line 1 times line 10) 12.00 15.00 16.00 17.00 18.00 19.00 19.00 19.00 10.0	7.0
9.00 Net revenue from stand-alone CHIP 10.00 Stand-al one CHIP charges Stand-al one 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) 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 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Insured patients Insured patients Louis Lo	8. 0
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) Dither 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) 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 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients Total (col. patients patients patients patients + col. 2) 1. 00 2. 00 3. 00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	
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) 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) 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 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 19.00 Uninsured patients Insured patients Patients 10.00 2.00 3.00 10.00 Charity care charges and uninsured discounts (see instructions) 10.00 Charity care charges and uninsured discounts (see instructions) 10.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 10.00 Payments received from patients for amounts previously written off as 10.00 Charity care	9. 0
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) 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) 7.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	10. 0
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) 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) Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	11. 0
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) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	12. 0
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 18.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured Insured patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	–
10) 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 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	13. 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) 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 17.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	14. 0
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 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	15. 0
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 (Sovernment grants, appropriations or transfers for support of hospital operations) 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) Uninsured patients patients	16. 0
instructions for each line) Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	- 10.0
17. 00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	17. 0
19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	18. 0
Uninsured patients Insured patients Total (col. + col. 2)	19. 0
Uncompensated care cost (see instructions for each line) 20.00 Charity care charges and uninsured discounts (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	
Uncompensated care cost (see instructions for each line) 20.00 Charity care charges and uninsured discounts (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	1
Uncompensated care cost (see instructions for each line) 20.00 Charity care charges and uninsured discounts (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	
20.00 Charity care charges and uninsured discounts (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	
21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care	
instructions) 22.00 Payments received from patients for amounts previously written off as charity care	20. 0
22.00 Payments received from patients for amounts previously written off as charity care	21. 0
charity care	1 22 2
	22. 0
23.00 Cost of charity care (see instructions)	23. 0
23. 00 Cost of Charty Care (See Histractions)	23.0
1.00	

24.00

25.00

25.01

26.00

27. 00

27.01

28.00

29.00

30.00

31.00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

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

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Medicare allowable bad debts (see instructions)

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

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

25.00

25. 01

27.01

stay limit

Heal th	Financial Systems	PARIS COMMUNITY	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF E			Provi der CCN: 14-1320		Peri od:	Worksheet A	
					From 01/01/2023 Fo 12/31/2023	Date/Time Pre	pared:
						5/23/2024 4:0	
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassified	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP		3, 493, 913			3, 822, 390	1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	466, 056	2, 300, 328 10, 156, 697	10, 622, 753		2, 661, 420 10, 795, 854	4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	5, 986, 416	9, 113, 122			14, 538, 107	5. 01
5. 02	00560 ADMITTING	2, 081, 253	3, 474, 613			5, 555, 236	5. 02
7.00	00700 OPERATION OF PLANT	1, 249, 995	1, 712, 810			2, 958, 806	
8. 00	00800 LAUNDRY & LINEN SERVICE	0	134, 520			134, 520	
9.00	00900 HOUSEKEEPI NG	1, 098, 044	481, 149			1, 579, 193	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	852, 758	827, 580	1, 680, 338		516, 845 1, 162, 893	1
13. 00	01300 NURSING ADMINISTRATION	350, 255	74, 846	-		425, 101	
15. 00	01500 PHARMACY	395, 181	4, 939, 698			570, 690	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	692, 160	191, 982	884, 142		884, 142	1
17. 00	01700 SOCIAL SERVICE	0	702	702	2 0	702	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	4, 731, 071	1, 143, 239	5, 874, 310	-47, 201	5, 827, 109	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 109, 816	8, 084, 387	11, 194, 203	-11, 143, 928	50, 275	50.00
53. 00	05300 ANESTHESI OLOGY	2, 154, 351	669, 898			2, 601, 640	ı
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 549, 839	2, 346, 357			4, 685, 049	ı
60.00	06000 LABORATORY	1, 079, 793	2, 840, 630			2, 919, 707	
65. 00	06500 RESPI RATORY THERAPY	700, 412	241, 712	942, 124	-59, 356	882, 768	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 440, 249	337, 611	1, 777, 860	-3, 594	1, 774, 266	
69. 00	06900 ELECTROCARDI OLOGY	0	95, 571	95, 571		204, 028	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39, 041	39, 041		8, 330, 771	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		., .==, .==	4, 425, 188 5, 066, 890	
74. 00	07400 RENAL DIALYSIS	544, 301	443, 646	-		941, 949	
7 1. 00	OUTPATIENT SERVICE COST CENTERS	011,001	110,010	707, 717	10, 770	711, 717	, 1. 00
88. 00	08800 RURAL HEALTH CLINIC	10, 228, 615	4, 785, 695	15, 014, 310	0	15, 014, 310	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	509, 096	181, 599			690, 695	1
88. 02	08802 RURAL HEALTH CLINIC III	633, 376	147, 851	781, 227		781, 227	1
88. 03	08803 RURAL HEALTH CLINIC IV	2, 284, 280	948, 708			3, 232, 988	1
88. 04 88. 05	08804 RURAL HEALTH CLINIC V 08805 RURAL HEALTH CLINIC VI	504, 126 0	171, 923 1, 423			676, 049 1, 423	1
90. 00	09000 CLINIC	1, 002, 751	212, 603			1, 180, 148	ł
90. 01	04951 CHEMO/PAI N	2, 663, 946	1, 602, 824			3, 713, 383	
90. 02	09002 SENI OR CARE	98, 094	611, 476			708, 218	ł
90. 03	09003 SLEEP LAB	0	0	(o o	0	90. 03
90. 04	09001 ORTHOPEDI CS	1, 444, 228	316, 176			1, 755, 601	
90. 05	09004 BEHAVI ORAL HEALTH CLINIC	0	90				90.05
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 574, 090	2, 556, 306	5, 130, 396	-62, 859	5, 067, 537	
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	1, 590, 623	436, 647	2, 027, 270	-8, 841	2, 018, 429	95. 00
	09600 DURABLE MEDICAL EQUIP RENTED	0	34, 400				1
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		0		0		113. 00
118.00		53, 015, 175	65, 151, 773	118, 166, 948	3 0	118, 166, 948	J118. 00
192 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 553, 207	5, 114, 620	7, 667, 827	7 0	7, 667, 827	192 00
	19202 HOME HEALTHCARE SVC	512, 612	104, 122				
	19201 NAL CLINIC	435, 603	148, 160			583, 763	
200.00		56, 516, 597	70, 518, 675				

Provider CCN: 14-1320

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm

				5/23/2024 4:0	01 pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-63, 771	3, 758, 619		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	O	2, 661, 420		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-297, 637	10, 498, 217		4.00
5. 01	00590 ADMINISTRATIVE AND GENERAL	-2, 993, 345	11, 544, 762		5. 01
5. 02	00560 ADMITTING	-201	5, 555, 035		5. 02
7. 00	00700 OPERATION OF PLANT	-5, 783	2, 953, 023		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	-5, 765	134, 520		8. 00
9. 00	00900 HOUSEKEEPING	-33	1, 579, 160		9. 00
	01000 DI ETARY				1
10.00		-34, 775	482, 070		10.00
11. 00	01100 CAFETERI A	-187, 198	975, 695		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	425, 101		13. 00
15. 00	01500 PHARMACY	-64, 654	506, 036		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-3, 788	880, 354		16. 00
17. 00	01700 SOCIAL SERVICE	0	702		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-866, 151	4, 960, 958		30. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-4, 969	45, 306		50. 00
53.00	05300 ANESTHESI OLOGY	-1, 905, 144	696, 496		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-760, 830	3, 924, 219		54.00
60.00	06000 LABORATORY	-212	2, 919, 495		60.00
65. 00	06500 RESPI RATORY THERAPY	-6	882, 762		65. 00
66. 00	06600 PHYSI CAL THERAPY	-43, 113	1, 731, 153		66. 00
69. 00	06900 ELECTROCARDI OLOGY	-74, 577	129, 451		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	74, 377	8, 330, 771		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	4, 425, 188		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	5, 066, 890		73. 00
74. 00	07400 RENAL DIALYSIS	1			
74.00		-483	941, 466		74. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	-265, 078	14 740 222		- 00 00
88. 00			14, 749, 232		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	-734	689, 961		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	-3, 197	778, 030		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	-349	3, 232, 639		88. 03
88. 04	08804 RURAL HEALTH CLINIC V	-1, 563	674, 486		88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	1, 423		88. 05
90.00	09000 CLI NI C	-644, 574	535, 574		90.00
90. 01	04951 CHEMO/PAI N	-765, 436	2, 947, 947		90. 01
90. 02	09002 SENI OR CARE	-3, 028	705, 190		90. 02
90. 03	09003 SLEEP LAB	0	0		90. 03
90.04	09001 ORTHOPEDI CS	-1, 411, 154	344, 447		90. 04
90.05	09004 BEHAVI ORAL HEALTH CLINIC	-750	-660		90. 05
91.00	09100 EMERGENCY	-853, 172	4, 214, 365		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				1
95.00	09500 AMBULANCE SERVI CES	-20, 140	1, 998, 289		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP RENTED	0	11, 311		96. 00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	11, 511		70.00
112 00	11300 I NTEREST EXPENSE	0	O		113. 00
		1			•
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-11, 275, 845	106, 891, 103		118. 00
100.00	NONREI MBURSABLE COST CENTERS		7 (/7 00=		100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	7, 667, 827		192. 00
	19202 HOME HEALTHCARE SVC	0	616, 734		192. 01
	19201 NAL CLINIC	0	583, 763		192. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	-11, 275, 845	115, 759, 427		200. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: Worksheet A-0
From 01/01/2023
To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4:01 pm Provider CCN: 14-1320

					5/23/2024 4:01 pm
		Increases			
	Cost Center	Li ne #	Salary	0ther	
	2. 00 A - RENTAL EXPENSE	3. 00	4. 00	5. 00	
1. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	361, 092	1.00
1.00	EQUIP	2.00	۷	301, 092	1.00
2. 00	LQUIF	0.00	o	0	2. 00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5. 00		0.00	o	0	5.00
6. 00		0.00	o	0	6.00
7. 00		0.00	0	0	7.00
8. 00		0.00	0	0	8.00
9. 00		0.00	0	0	9.00
		0.00	-1	-	•
10.00			0	0	10.00
11. 00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14. 00		0.00	0	0	14. 00
	U CAFETERIA		U	361, 092	
1 00	B - CAFETERIA	11 00	F22 202	(20 F01	1 00
1. 00	CAFETERI A	11.00	533, 392	629, 501	1.00
	0		533, 392	629, 501	
1 00	C - EKG	40.00	72 407		1.00
1.00	ELECTROCARDI OLOGY	69.00	73, 497	0	1.00
2.00		0.00		0	2. 00
	D DDODEDTY LNCUDANCE		73, 497	0	
1 00	D - PROPERTY INSURANCE	1 00		220 477	1.00
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	328, 477	1.00
	FIXT — — — —	+			
	0		U	328, 477	
4 00	E - PATIENT SUPPLIES	74 00	ما	0 005 700	1 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	8, 305, 709	1.00
2 00	PATI ENTS	(0.00		40	2.00
2.00	ELECTROCARDI OLOGY	69. 00	0	48	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6. 00
7. 00		0.00	0	0	7. 00
8.00		0.00	0	0	8. 00
9.00		0.00	0	0	9. 00
10.00		0.00	0	0	10.00
11. 00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13. 00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15. 00
16.00		0.00	0	0	16. 00
17.00		0.00	0	0	17. 00
18.00		0.00	0_	0	18. 00
	0		0	8, 305, 757	
	F - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	5, 066, 890	 1. 00
2.00		0.00	O	0	2. 00
3.00		0.00	O	0	3. 00
4.00		0.00	O	0	4. 00
5.00		0.00	О	0	5. 00
6.00		0.00	О	0	6. 00
7.00		0.00	o	0	7. 00
8.00		0.00	ol	0	8. 00
9.00		0.00	О	0	9. 00
10.00		0.00	ol	0	10.00
11. 00		0.00	o	0	11. 00
12.00		0.00	ol	0	12. 00
13. 00		0.00	0	0	13. 00
14. 00		0.00	ol	0	14. 00
15. 00		0.00	ő	n	15. 00
		— — " "		5, 066, 890	.5. 66
	H - BENEFITS RECLASS		٦	5, 555, 676	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	174, 020	1.00
1. 50	TOTALS	— — .50		174, 020	1.00
	I - STRESS TEST		٠ <u>٠</u>	174,020	
1. 00	ELECTROCARDI OLOGY	69. 00	27, 705	7 270	1.00
1.00	0		27, 705	<u>7, 279</u> 7, 279	1.00
	1	ı	27, 700	1,217	ı

Heal th	n Financial Systems		PARIS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLA	SSI FI CATI ONS			Provi der (CCN: 14-1320	Peri od: From 01/01/2023		
						To 12/31/2023	Date/Time Pro 5/23/2024 4:0	
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	J - IMPLANT EXPENSE							
1.00	IMPL. DEV. CHARGED TO	72.00	0	4, 425, 188				1. 00
	PATI ENT							
	0			4, 425, 188				
500.0	Grand Total: Increases		634, 594	19, 298, 204]			500. 00
	2.00 J - IMPLANT EXPENSE IMPL. DEV. CHARGED TO PATIENT 0	3.00	4.00	5. 00 4, 425, 188 4, 425, 188				

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Provi der CCN: 14-1320 Peri od:

						5/23/2024 4:	O1 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - RENTAL EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	910			1. 00
2.00	ADMINISTRATIVE AND GENERAL	5. 01	0	15, 806	0		2. 00
3.00	ADMI TTI NG	5. 02	0	630	0		3. 00
4.00	OPERATION OF PLANT	7. 00	0	3, 999	0		4. 00
5.00	DI ETARY	10.00	o	336	o		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	3, 026			6. 00
7. 00	OPERATING ROOM	50.00	0	317, 373			7. 00
8. 00	ANESTHESI OLOGY	53.00	0	2, 459	-		8. 00
9. 00	LABORATORY	60.00	0	152			9. 00
	RESPIRATORY THERAPY	65.00	0				1
10.00		•	U	666			10.00
11. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	U	13, 979	0		11. 00
40.00	PATI ENTS			400			40.00
12. 00	CHEMO/PAIN	90. 01	0	109			12. 00
13. 00	SENI OR CARE	90. 02	0	1, 352			13. 00
14.00	AMBULANCE SERVICES	<u>95.</u> 00	0	295			14. 00
	0		0	361, 092			
	B - CAFETERIA						
1.00	DI ETARY	10.00	533, 392	629, 501	0		1. 00
		T	533, 392	629, 501			
	C - EKG		,				
1.00	ADULTS & PEDIATRICS	30.00	18, 980	0	0		1. 00
2. 00	RESPIRATORY THERAPY	65. 00	54, 517				2. 00
2.00	0		73, 497	0			2.00
	D - PROPERTY INSURANCE		75, 477				
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	328, 477	12		1.00
1.00	O DENERAL TO SENERAL T	— — - 3. 01 	— — — ŏ	328, 477			1.00
	C DATIENT CUDDITIES		U	320, 411			_
4 00	E - PATIENT SUPPLIES	4 00					4 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9			1.00
2.00	ADMINISTRATIVE AND GENERAL	5. 01	0	42, 708			2. 00
3.00	DI ETARY	10. 00	0	253			3. 00
4.00	PHARMACY	15. 00	0	40, 250			4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	24, 827	0		5. 00
6.00	OPERATING ROOM	50.00	0	6, 398, 831	0		6. 00
7.00	ANESTHESI OLOGY	53.00	0	121, 738	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	o	194, 477	ol		8. 00
9.00	LABORATORY	60.00	0	1, 000, 564	0		9. 00
10.00	RESPIRATORY THERAPY	65. 00	0	4, 146			10. 00
11. 00	PHYSI CAL THERAPY	66.00	0	3, 330			11. 00
12. 00	RENAL DI ALYSI S	74.00	0	44, 961	0		12. 00
13. 00	CLINIC	90.00	0		-		13. 00
			U	130			1
14.00	CHEMO/PAIN	90. 01	0	336, 641	0		14. 00
15. 00	ORTHOPEDI CS	90. 04	0	4, 803			15. 00
16. 00	EMERGENCY	91.00	0	60, 630			16. 00
17. 00	AMBULANCE SERVICES	95.00	0	4, 370			17. 00
18. 00	DURABLE MEDICAL EQUIP	96.00	0	23, 089	0		18. 00
	RENTED	↓					
	0		0	8, 305, 757			
	F - DRUGS						
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	420			1. 00
2.00	DI ETARY	10.00	0	11	0		2. 00
3.00	PHARMACY	15. 00	o	4, 723, 939	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	368			4. 00
5. 00	OPERATING ROOM	50.00	ō	2, 536			5. 00
6. 00	ANESTHESI OLOGY	53.00	n	98, 412			6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	16, 670			7. 00
8. 00	RESPIRATORY THERAPY	65. 00	0	10, 070	-		8. 00
9. 00	PHYSICAL THERAPY	66. 00	0	264			9. 00
	ELECTROCARDI OLOGY		o o				10.00
10.00		69.00	O O	72 1 027			1
11. 00	RENAL DIALYSIS	74.00	0	1, 037			11. 00
12.00	CLINIC	90.00	0	92			12.00
13.00	CHEMO/PAIN	90. 01	0	216, 637			13. 00
14.00	EMERGENCY	91.00	0	2, 229			14. 00
15.00	AMBULANCE SERVICES	<u> </u>	0	<u>4, 1</u> 76			15. 00
	0		<u> </u>	5, 066, 890			
	H - BENEFITS RECLASS		·				
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	174, 020	0		1.00
	TOTALS		— — - ō	174, 020			1
	I - STRESS TEST			, 320			
1.00	CLINIC	90.00	27, 705	7, 279	0		1.00
50	0	— /0. 30					
	1-	ı	27,700	1,217			1

Heal th Financial Systems

PARIS COMMUNITY HOSPITAL

Provider CCN: 14-1320
Period:
From 01/01/2023
To 12/31/2023
Pate/Time Prepared:
5/23/2024 4: 01 pm

						5/23/2024 4:0	O I DIII
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	J - IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	4, 425, 188	3 (1.00
	0		0	4, 425, 188	3		
500.00	Grand Total: Decreases		634, 594	19, 298, 204	1		500.00

Provider CCN: 14-1320

				j	o 12/31/2023	Date/Time Prep 5/23/2024 4:0	
				Acqui si ti ons		0,20,2021 110	, p
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
PA	ART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00 L	and	1, 626, 832	0	(0	0	1. 00
2.00 L	and Improvements	3, 656, 398	637, 283	(637, 283	0	2. 00
3.00 B	uildings and Fixtures	68, 149, 938	5, 050, 600	(5, 050, 600	0	3. 00
4.00 B	uilding Improvements	6, 204, 716	1, 427, 876	(1, 427, 876	0	4. 00
5.00 F	ixed Equipment	0	0	(0	0	5. 00
6.00 M	lovable Equipment	26, 475, 688	2, 635, 561	(2, 635, 561	0	6. 00
7.00 H	IT designated Assets	0	0	(0	0	7. 00
8. 00 S	Subtotal (sum of lines 1-7)	106, 113, 572	9, 751, 320	(9, 751, 320	0	8. 00
9.00 R	econciling Items	0	0	(0	0	9. 00
10. 00 To	otal (line 8 minus line 9)	106, 113, 572	9, 751, 320	(9, 751, 320	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
_	ART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
	and	1, 626, 832	0				1. 00
	and Improvements	4, 293, 681	0				2. 00
	uildings and Fixtures	73, 200, 538	0				3. 00
	uilding Improvements	7, 632, 592	0				4. 00
	i xed Equi pment	0	0				5. 00
	lovable Equipment	29, 111, 249	0				6. 00
	IIT designated Assets	0	0				7. 00
	ubtotal (sum of lines 1-7)	115, 864, 892	0				8. 00
	deconciling Items	0	0				9. 00
10. 00 T	otal (line 8 minus line 9)	115, 864, 892	0				10. 00

Heal th	Financial Systems	PARIS COMMUNIT	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		nared:
					10 12/01/2020	5/23/2024 4:0	1 pm
			Sl	UMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 282, 464	0	1, 211, 44	9 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2, 300, 328	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 582, 792	0	1, 211, 44	9 0	0	3.00
		SUMMARY OF	CAPITAL				
	Cost Center Description	0ther	Total (1) (sum	1			
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	3, 493, 913	3			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2, 300, 328	1			2. 00
3. 00	Total (sum of lines 1-2)		5, 794, 241				3. 00
		-1		1			

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-1320 Period: From 01/01/2023 To 12/31/2023 Part III Date/Time Prepa 5/23/2024 4:01 Cost Center Description Gross Assets Leases Gross Assets For Ratio Insurance Insura	
Cost Center Description Cost Center Descripti	
COMPUTATION OF RATIOS Cost Center Description Cost Center Description	red:
Cost Center Description Gross Assets Capitalized Gross Assets Ratio (see Insurance Leases for Ratio instructions)	
Leases for Ratio instructions)	
(col. 1 - col.)	
2)	
1.00 2.00 3.00 4.00 5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1. 00 NEW CAP REL COSTS-BLDG & FLXT 86, 753, 643 0. 748748 0	1.00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 29, 111, 249 0 29, 111, 249 0. 251252 0	2.00
3.00 Total (sum of lines 1-2) 115, 864, 892 0 115, 864, 892 1.000000 0	3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL	
Cost Center Description Taxes Other Total (sum of Depreciation Lease	
Capi tal -Rel ate col s. 5	
d Costs through 7)	
6.00 7.00 8.00 9.00 10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 2, 218, 693 0	1. 00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 2, 300, 328 361, 092	2. 00
3.00 Total (sum of lines 1-2) 0 0 4,519,021 361,092	3. 00
SUMMARY OF CAPITAL	
Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum	
instructions instructions Capital -Relate of cols. 9	
d Costs (see through 14)	
instructions)	
11.00 12.00 13.00 14.00 15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1. 00 NEW CAP REL COSTS-BLDG & FIXT 1, 211, 449 328, 477 0 0 3, 758, 619	1. 00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 2, 661, 420	2. 00
3.00 Total (sum of lines 1-2) 1,211,449 328,477 0 0 6,420,039	3. 00

Period: Worksheet A-8
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm

					0 12/31/2023	5/23/2024 4:0	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	TI NEW OAR	1.00	2.00	3.00	4. 00	5. 00	1.00
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	Α	-63, 7/1	NEW CAP REL COSTS-BLDG & FLXT	1. 00	9	1. 00
	2)						
2.00	Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	0	2.00
	REL COSTS-MVBLE EQUIP (chapter			EQUI P			
0.00	2)				0.00		0.00
3.00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
	discounts (chapter 8)						
5.00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
0.00	suppliers (chapter 8)		O		0.00		0.00
7.00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0. 00	0	8. 00
6.00	(chapter 21)		U		0.00	U	0.00
9.00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10.00	Provi der-based physician	A-8-2	-6, 140, 784			0	10.00
	adjustment						
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	0			0	12. 00
	transactions (chapter 10)		_				
13. 00	Laundry and linen service		0		0.00		
14.00	Cafeteria-employees and guests		-187, 198	CAFETERI A	11. 00		
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
	patients		_			_	
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and	В	-3. 788	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts		3, 733	meet ene needinge a eneman	.0.00		10.00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0.00		ı
	interest, finance or penalty						
	charges (chapter 21)		_			_	
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments]					
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14)	1 400	^	DUVSICAL THEDADV	44.00		24.00
∠4. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - NEW CAP REL		^	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
20.00	COSTS-BLDG & FIXT			FIXT	1.00	J	20.00
27. 00	Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
	COSTS-MVBLE EQUIP			EQUI P			
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00 29. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00		30.00
55. 66	therapy costs in excess of	"	0	3031 Genter Bereteu	37.00		55. 55
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	^	*** Cost Center Deleted ***	68. 00		31. 00
31.00	pathology costs in excess of	A 0-3	0	3031 Genter Dereteu	00.00		31.00
	limitation (chapter 14)						

From 01/01/2023 | To 12/31/2023 | Date.

Date/Time Prepared: 5/23/2024 4:01 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4. 00 5.00 32.00 CAH HIT Adjustment for 32. 00 0.00 Depreciation and Interest 33.00 NONALLOWABLE EXPENSES Α -640 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.00 34.00 NONALLOWABLE EXPENSES Α -247, 466 ADMINISTRATIVE AND GENERAL 5.01 34.00 34. 01 NONALLOWABLE EXPENSES -99 ADMITTING 34. 01 Α 5.02 0 NONALLOWABLE EXPENSES -137 OPERATING ROOM 50.00 34.02 34.02 Α 34.03 NONALLOWABLE EXPENSES Α -339 RADI OLOGY-DI AGNOSTI C 54.00 0 34.03 NONALLOWABLE EXPENSES -147 RENAL DIALYSIS 34.04 Α 74.00 34.04 NONALLOWABLE EXPENSES -172, 866 RURAL HEALTH CLINIC 34.05 88.00 34.05 0 Α 34.06 NONALLOWABLE EXPENSES Α -694 RURAL HEALTH CLINIC II 88 01 34 06 34.07 NONALLOWABLE EXPENSES -3,181 RURAL HEALTH CLINIC III 88.02 34.07 Α -273 RURAL HEALTH CLINIC IV 34.08 NONALLOWABLE EXPENSES Α 88.03 34.08 NONALLOWABLE EXPENSES -1,563 RURAL HEALTH CLINIC V 34.09 88.04 0 34.09 Α -357 CHEMO/PAIN 34.10 NONALLOWABLE EXPENSES Α 90.01 34.10 NONALLOWABLE EXPENSES -3, 021 SENI OR CARE 90.02 34.11 34.11 NONALLOWABLE EXPENSES 34. 12 Α -10 ORTHOPEDICS 90.04 34. 12 -2, 083 AMBULANCE SERVICES 35.00 NONALLOWABLE EXPENSES Α 95.00 0 35, 00 35.01 ANESTHESIA SALARIES Α -1, 133, 551 ANESTHESI OLOGY 53.00 ol 35.01 35. 02 ANESTHESIA BENEFITS Α -296,580EMPLOYEE BENEFITS DEPARTMENT 4.00 35.02 -417 EMPLOYEE BENEFITS DEPARTMENT OTHER INCOME 36.00 В 4.00 36.00 OTHER INCOME -656, 294 ADMINISTRATIVE AND GENERAL ol 36.01 В 5.01 36.01 OTHER INCOME -102 ADMI TTI NG 37.00 37.00 В 5.02 -5, 783 OPERATION OF PLANT 37.01 OTHER INCOME В 7.00 37.01 37.02 OTHER INCOME -33 HOUSEKEEPI NG 9.00 0 37.02 В 37.03 OTHER INCOME В -34, 775 DI ETARY 10.00 0 37.03 OTHER INCOME -64, 654 PHARMACY 37.04 В 15.00 37.04 37.05 OTHER INCOME В -27 ADULTS & PEDIATRICS 30.00 ol 37.05 -2, 503 OPERATING ROOM OTHER INCOME 37.06 В 50.00 0 37.06 37.07 OTHER INCOME В -56 ANESTHESI OLOGY 53.00 ol 37.07 OTHER INCOME -1, 516 RADI OLOGY-DI AGNOSTI C 37.08 В 54.00 0 37.08 OTHER INCOME -212 LABORATORY 37.09 37 09 В 60 00 O -6 RESPIRATORY THERAPY 0 37.10 OTHER INCOME В 65.00 37. 10 37. 11 OTHER INCOME В -43, 113 PHYSICAL THERAPY 66.00 37.11 37.12 OTHER INCOME В -336 RENAL DIALYSIS 74.00 0 37.12 -92, 212 RURAL HEALTH CLINIC ol OTHER INCOME 88 00 37 13 В 37 13 -40 RURAL HEALTH CLINIC II OTHER INCOME 37.14 В 88.01 0 37.14 37.15 OTHER INCOME В -16 RURAL HEALTH CLINIC III 88.02 37. 15 OTHER INCOME В -76 RURAL HEALTH CLINIC IV 88.03 37.16 37.16 0 -4, 671 CLI NI C 37 17 OTHER INCOME 90 00 37 17 В -2, 021 CHEMO/PAI N 37. 18 OTHER INCOME В 90.01 0 37.18 OTHER INCOME -7 SENI OR CARE 90.02 37.19 37.19 В 37. 20 OTHER INCOME -750BEHAVIORAL HEALTH CLINIC 90.05 37. 20 В 0 37. 21 OTHER INCOME В -35 EMERGENCY 91.00 ol 37. 21 37. 22 OTHER INCOME В -18, 057 AMBULANCE SERVICES 95.00 0 37. 22 -18, 466 ADMINI STRATI VE AND GENERAL 37.23 LOBBYING DUES Α 5.01 37.23 -2, 071, 119 ADMINI STRATI VE AND GENERAL MEDICAID ASSESSMENT FEES 5.01 37. 24 37.24 Α 50.00 TOTAL (sum of lines 1 thru 49) -11, 275, 845 50.00 (Transfer to Worksheet A,

column 6, line 200.)

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

⁽²⁾ Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm

							5/23/2024 4:0)1 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	916, 124	866, 12	24 50,000	0	0	1. 00
2.00		OPERATING ROOM	2, 329					1
3. 00		ANESTHESI OLOGY	821, 537	771, 53				
4. 00		RADI OLOGY-DI AGNOSTI C	758, 975					1
5. 00		LABORATORY	70, 000		70,000		0	1
6. 00		RESPI RATORY THERAPY	24, 554		0 24, 554		_	1
7.00		ELECTROCARDI OLOGY	86, 577	74, 5			0	
8. 00		RENAL DI ALYSI S	120, 000		0 120,000			0.00
9.00		CLI NI C	689, 903	639, 90			0	
10. 00		CHEMO/PAIN	820, 289			l .	0	
11. 00		SENI OR CARE	33, 150		0 33, 150			
12.00	90. 04	ORTHOPEDI CS	1, 411, 144	1, 411, 14	14 C	0	0	12. 00
13.00	91.00	EMERGENCY	2, 753, 137	853, 13	1, 900, 000	0	0	13.00
200.00			8, 507, 719	6, 140, 78	2, 366, 935		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RO	CE Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0		0 0	0	0	1. 00
2.00	50.00	OPERATING ROOM	0		0 0	0	0	2.00
3.00	53. 00	ANESTHESI OLOGY	0		o o	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	0	0	1
5. 00		LABORATORY	0		o o	0	0	1
6. 00		RESPI RATORY THERAPY	0		0		l o	
7. 00		ELECTROCARDI OLOGY	0		0	_	0	
8. 00		RENAL DIALYSIS				ļ	0	1
9. 00		CLI NI C				_	0	1
10. 00		CHEMO/PAIN					0	1
		SENIOR CARE					0	
11. 00			0				_	
12. 00		ORTHOPEDI CS	0		0 0		0	1
13.00	91.00	EMERGENCY	0		0 0	_	0	
200.00			0		0 0		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RC		Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	17,00	17.00	10.00		
1. 00	1.00	2.00 ADULTS & PEDIATRICS	15. 00 0	16. 00	17. 00 0	18. 00 866, 124		1. 00
		OPERATING ROOM						1
2.00			0		0 0	, , ,		2.00
3.00		ANESTHESI OLOGY	0		0 0			3.00
4.00		RADI OLOGY-DI AGNOSTI C	0		0 0			4. 00
5.00		LABORATORY	0		0 0	1		5. 00
6. 00		RESPI RATORY THERAPY	0		0 0			6. 00
7.00		ELECTROCARDI OLOGY	0		0 0			7. 00
8.00		RENAL DIALYSIS	0		0 0	_		8. 00
9.00	90. 00	CLI NI C	0		0 0	639, 903		9. 00
10.00	90. 01	CHEMO/PAIN	0		0 0	763, 058		10.00
11.00		SENI OR CARE	0		0 0			11. 00
12.00		ORTHOPEDI CS	0		0 0	1, 411, 144		12.00
13. 00		EMERGENCY	0		o o			13. 00
200.00			l o		o o		1	200. 00
	!		'	1	-1	2,	1	

	ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 14-1320 F	Peri od:	Worksheet B	
				F	From 01/01/2023 Fo 12/31/2023	Part I	
					10 12/31/2023	Date/Time Pre 5/23/2024 4:0	
			CAPI TAL REL	ATED COSTS		372372024 4.0	T DIII
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
	'	for Cost	FLXT	EQUI P	BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)					
	Tanana and an and an	0	1. 00	2. 00	4. 00	4A	
4 00	GENERAL SERVICE COST CENTERS	0.750 (40	0.750 (40				1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	3, 758, 619	3, 758, 619			I	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	2, 661, 420	05 (05	2, 661, 420		I	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	10, 498, 217	25, 625			44 000 47/	4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	11, 544, 762	564, 838				
5. 02 7. 00	00560 ADMITTING 00700 OPERATION OF PLANT	5, 555, 035 2, 953, 023	90, 947 327, 878			6, 299, 291	1
8. 00	00800 LAUNDRY & LINEN SERVICE	134, 520	26, 842			3, 866, 766 180, 368	1
9. 00	00900 HOUSEKEEPING	1, 579, 160	18, 880				1
10.00	01000 DI ETARY	482, 070	84, 810				1
11. 00	01100 CAFETERI A	975, 695	38, 590				
13. 00	01300 NURSI NG ADMI NI STRATI ON	425, 101	38, 148				
15. 00	01500 PHARMACY	506, 036	24, 077				
16. 00		880, 354	61, 672				
17. 00	01700 SOCIAL SERVICE	702	4, 312				
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	702	4, 312	3, 03-	+ 0	0,000	17.00
30 00	03000 ADULTS & PEDI ATRI CS	4, 960, 958	387, 174	274, 152	1, 333, 333	6, 955, 617	30.00
00.00	ANCI LLARY SERVI CE COST CENTERS	1, 700, 700	007, 171	271,102	1,000,000	0, 700, 017	30.00
50. 00	05000 OPERATI NG ROOM	45, 306	388, 970	275, 424	879, 954	1, 589, 654	50.00
53. 00	05300 ANESTHESI OLOGY	696, 496	3, 290				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 924, 219	203, 594				
60. 00	06000 LABORATORY	2, 919, 495	84, 838				
65.00	06500 RESPIRATORY THERAPY	882, 762	10, 532				
66. 00	06600 PHYSI CAL THERAPY	1, 731, 153	647, 051	458, 162			
	06900 ELECTROCARDI OLOGY	129, 451	14, 485				•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 330, 771	0	. (•
72.00		4, 425, 188	0		ol	4, 425, 188	
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 066, 890	0		ol	5, 066, 890	73.00
74.00	07400 RENAL DIALYSIS	941, 466	0	(154, 015	1, 095, 481	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	14, 749, 232	0	1		14, 749, 232	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	689, 961	41, 465	29, 361	0	760, 787	
88. 02	08802 RURAL HEALTH CLINIC III	778, 030	0	(0	778, 030	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	3, 232, 639	301, 396			3, 747, 449	
88. 04	08804 RURAL HEALTH CLINIC V	674, 486	43, 981	31, 142		749, 609	
88. 05	08805 RURAL HEALTH CLINIC VI	1, 423	0	(
90. 00	09000 CLI NI C	535, 574	17, 001				
90. 01	04951 CHEMO/PAI N	2, 947, 947	42, 681				
90. 02	09002 SENI OR CARE	705, 190	0	(
	09003 SLEEP LAB	0	0	(90. 03
	09001 ORTHOPEDI CS	344, 447	50, 947				
	09004 BEHAVI ORAL HEALTH CLINIC	-660	11, 831	8, 378		19, 549	
	09100 EMERGENCY	4, 214, 365	142, 474	100, 884	728, 365		
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	1 000 200	0		450,000	2 440 272	05 00
95. 00	09500 AMBULANCE SERVICES	1, 998, 289	0		450, 083		
96. 00	09600 DURABLE MEDICAL EQUIP RENTED SPECIAL PURPOSE COST CENTERS	11, 311	0		0	11, 311	96. 00
113 00	11300 I NTEREST EXPENSE						113. 00
118.00	l l	106, 891, 103	3, 698, 329	2, 618, 729	10, 541, 987	106, 788, 122	•
110.00	NONREI MBURSABLE COST CENTERS	100, 071, 103	3, 070, 327	2,010,72	10, 341, 707	100, 700, 122	1110.00
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	7, 667, 827	0	(7, 667, 827	192 00
	19202 HOME HEALTHCARE SVC	616, 734	0			616, 734	•
	2 19201 NAL CLINIC	583, 763	60, 290	1			
200.00	1 1	000,700	30, 270	12, 07			200. 00
201.00			O	(ol		201. 00
202.00		115, 759, 427	3, 758, 619	2, 661, 420			

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1320

				Т	o 12/31/2023	Date/Time Pre 5/23/2024 4:0	
	Cost Center Description	ADMI NI STRATI VE	ADMI TTI NG	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	i piii
		AND GENERAL		PLANT	LINEN SERVICE		
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	14, 203, 476					5. 01
5. 02	00560 ADMITTING	881, 013	7, 180, 304	1			5. 02
7. 00	00700 OPERATION OF PLANT	540, 802	0	.,,			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	25, 226	0	51, 202			8. 00
9. 00	00900 HOUSEKEEPI NG	268, 825	0	36, 015		2, 226, 952	9. 00
10.00	01000 DI ETARY	100, 321	0	161, 779		79, 506	1
11. 00	01100 CAFETERI A	166, 787	0	73, 612		36, 177	1
13.00	01300 NURSI NG ADMI NI STRATI ON	82, 429	0	72, 769		35, 762	
15.00	01500 PHARMACY	92, 165	0	45, 929		22, 572	1
16.00	01600 MEDICAL RECORDS & LIBRARY	165, 250	0	,			1
17. 00	01700 SOCIAL SERVICE	1, 128	0	8, 226	0	4, 043	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	072.004	1 1/0 27/	720 540	25/ 70/	2/2 0/1	20.00
30. 00	ANCI LLARY SERVICE COST CENTERS	972, 806	1, 160, 274	738, 549	256, 796	362, 961	30.00
50. 00	05000 OPERATING ROOM	222, 327	269, 683	741, 977	0	364, 645	50.00
53. 00	05300 ANESTHESI OLOGY	138, 595	207, 003	1			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	698, 383	740, 008	1			1
60. 00	06000 LABORATORY	471, 317	562, 589	1	0	79, 532	
65. 00	06500 RESPIRATORY THERAPY	151, 539	215, 016	1		9, 873	
66. 00	06600 PHYSI CAL THERAPY	453, 688	528, 267	1		606, 585	
69. 00	06900 ELECTROCARDI OLOGY	25, 570	26, 226	1	0	13, 579	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 165, 133	1, 086, 950		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	618, 902	0	i	_	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	708, 650	855, 649				73. 00
74.00	07400 RENAL DI ALYSI S	153, 213	0		0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	2, 062, 777	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	106, 403	0	1		-	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	108, 814	0	0	-	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	524, 114	0	0	-	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	104, 840	0	0	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	199	0	0	0	0	88. 05
90. 00	09000 CLI NI C	117, 553	152, 498	1	-		
90. 01	04951 CHEMO/PAI N	527, 917	431, 479	1	_	40, 012	1
90. 02	09002 SENI OR CARE	102, 509	129, 963	1	_	0	90. 02
90. 03	09003 SLEEP LAB	117 400	120 4/4	1		0	90. 03
90. 04 90. 05	O9001 ORTHOPEDI CS O9004 BEHAVI ORAL HEALTH CLI NI C	117, 499	128, 464	1	_	47, 761	90. 04 90. 05
90.05	09100 EMERGENCY	2, 734	32, 604			11, 091	90.05
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	725, 321	860, 634	2/1, //5	U	133, 564	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	342, 427	0	0	0	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP RENTED	1, 582	0				
70.00	SPECIAL PURPOSE COST CENTERS	1,002					70.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		12, 948, 758	7, 180, 304	4, 180, 509	256, 796	2, 115, 363	
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	1, 072, 415	0	112, 053	0		
	19202 HOME HEALTHCARE SVC	86, 256	0				192. 01
	19201 NAL CLINIC	96, 047	0	115, 006	0		192. 02
200.00							200. 00
201.00		0	0	0	-		201. 00
202.00	TOTAL (sum lines 118 through 201)	14, 203, 476	7, 180, 304	4, 407, 568	256, 796	2, 226, 952	J202. 00

CONSECRATED RESERVICE CONTRIBUTION					10	12/31/2023	5/23/2024 4:0	
Common C	Cost Cente	er Description	DI ETARY	CAFETERI A	NURSI NG	PHARMACY		
SINERAL SERVICE COST CENTERS		·			ADMI NI STRATI ON		RECORDS &	
CENERAL SERVICE COST CENTERS								
1.00			10. 00	11. 00	13. 00	15. 00	16. 00	
2.00 002000 NEW CAP PEL COSTS-MYBLE EQUIP								
4. 00	1 1							
5.00	1 1							
5.00 OSCORD OPERATION OF PLANT 0.00								
7. 00 00700 OPERATI NO OF PLANT		ATIVE AND GENERAL						
8.00 008000 LAJUNDEY & LI NEN SERVICE								
9.00 000000 HOLSEKEPING	7. 00 00700 OPERATI ON	OF PLANT						7. 00
10.00	8.00 00800 LAUNDRY &	LINEN SERVICE						8. 00
11.00 01100 CAPETERIA	9. 00 00900 HOUSEKEEPI	NG						9. 00
13.00 01300 NURSI NS ADMINI STRATION 0 19,800 800,129 13.00 15.00 11500 PABMACY 0 0 22,440 0 841,988 15.00 11500 PABMACY 0 39,1288 0 0 0 0 0 0 1,551,386 16.00 17.00 1700 1700 2010 SOCIAL SERVICE 0 0 0 0 0 0 0 0 17.00 1700	10. 00 01000 DI ETARY		1, 058, 907					10. 00
15.00 O1500 PHARMACY O 22, 340 O 841, 988 15.00 17.00 O1700 SOCIAL SERVICE O O O O O O O 17.00 NATLEST ROUTE SERVICE COST CENTERS O O O O O O 17.00 NATLEST ROUTE SERVICE COST CENTERS O O O O O O O 17.00 NATLEST ROUTE SERVICE COST CENTERS O O O O O O O O 18.00 OSOOO ADURT SERVICE COST CENTERS O O O O O O O O O	11. 00 01100 CAFETERI A		0	1, 469, 115	5		ļ	11. 00
16. 00 01600 MEDICAL RECORDS & LI BRARY 0 39, 128 0 0 1, 561, 386 16. 00 17. 00 170	13.00 01300 NURSI NG AE	OMI NI STRATI ON	0	19, 800	800, 129			13. 00
17. 00 01700 01700 01700 01 0 0 0 0 0 0 0 0	15.00 01500 PHARMACY		0	22, 340	0	841, 988		15. 00
NAPATI ENT ROUTINE SERVICE COST CENTERS 1,058,907 266,388 264,799 0 44,241 30,00	16.00 01600 MEDICAL RE	CORDS & LIBRARY	0	39, 128	0	0	1, 561, 386	16. 00
30.00 03000 030000 03000 03000 03000 03000 03000 03000 030000 03000 03000 03000 03000 03000 03000 030000 03000 03000 03000 03000 03000 03000 030000 03000 03000 03000 03000 03000 03000 0300000 0300000 0300000 0300000 0300000000	17.00 01700 SOCIAL SEF	RVICE	0	0	0	0	0	17. 00
ANCILLARY SERVICE COST CENTERS 0 175, 801 172, 165 0 268, 739 50, 00 50, 00 50	INPATIENT ROUTIN	NE SERVICE COST CENTERS						
SOLIC DESCRIPTION ROOM 0 175, 801 172, 165 0 268, 739 80. 00 53. 00 00 00 03, 774 53. 00 053. 00 00 00 03, 774 53. 00 054. 00 00 00 00 00 027, 792 00. 00 00 00 00 027, 792 00. 00 00 00 00 027, 792 00. 00 00 00 00 027, 792 00. 00 00 00 03, 781 45. 00 00 00 00 027, 792 00. 00 00 00 03, 781 00 00 027, 792 00. 00 00 00 00 00 03, 781 00 00 00 00 00 00 00	30.00 03000 ADULTS & F	PEDI ATRI CS	1, 058, 907	266, 388	264, 799	0	44, 241	30. 00
S5.0 05300 AMESTHESI OLOGY 0 57,707 0 0 38,774 \$3.0	ANCI LLARY SERVI	CE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 144, 145 0 0 375, 814 54, 00 0 0 0 0 0 0 0 0 0	50. 00 05000 OPERATING	ROOM	0	175, 801	172, 165	0	268, 739	50.00
60.00 06000 LARDONATORY 0 0 1,042 0 0 227,792 00,00 65.00 06500 RESPIRATORY THERAPY 0 36,513 0 0 11,128 65.00 66.00 06600 PHYSI CAL THERAPY 0 81,419 0 0 97,521 66.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 26,602 69.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 26,602 69.00 69.00 07000 PHYSI CAL THERAPY 0 81,419 0 0 0 26,602 69.00 69.00 07000 PHYSI CAL THERAPY 0 0 0 0 0 26,602 69.00 69.00 07000 PHYSI CAL THERAPY 0 0 0 0 0 0 66,171 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 66,171 73.00 07300 PURS CHARGED TO PATIENTS 0 0 0 0 841,988 11,104 73.00 07300 PURS CHARGED TO PATIENTS 0 0 0 0 841,988 11,561,386 88.01 08700 PURS CHARGED TO PATIENTS 0 0 0 0 0 0 88.01 08700 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88.02 08800 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 0 88.02 08800 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 0 88.03 08800 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88.04 08800 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 0 88.04 08800 RURAL HEALTH CLINIC II 0 0 0 0 0 0 0 88.04 08800 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 0 0 88.04 08800 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 0 0 88.04 08800 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 0 0 88.05 08800 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 0 0 88.06 08800 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 0 0 89.07 07000 07000 0 0 0 0 0	53. 00 05300 ANESTHESI (DLOGY	0	57, 707	0	0	38, 774	53.00
65.00 06500 RESPI RATORY THERAPY 0 36,513 0 0 11,128 65,00 66.00 06600 PHYSI CAL THERAPY 0 81,419 0 0 26,602 69,00 71.00 07000 MELE CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 89,032 71.00 72.00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 89,032 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 74.00 07400 MELD DEV. CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 74.00 07400 MELD DEV. CHARGED TO PATIENTS 0 0 0 0 0 11,615 74.00 07400 MELD DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 11,615 75.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 11,615 76.00 07400 MELD DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 77.00 07400 MELD DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 78.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 78.00 07400 MELD DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 78.01 07400 07400 0 0 0 0 0 0 0 0 0	54. 00 05400 RADI OLOGY-	DI AGNOSTI C	o	144, 145	0	0	375, 814	54.00
66.00 06600 PHYSI CAL THERAPY 0 0 97, 521 0 0 0 97, 521 0 0 0 06900 06900 ELECTROCARDI OLOGY 0 0 5,721 0 0 0 0 26,602 69,00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 66,171 72.00 73.00 07300 PRISO CHARGED TO PATIENTS 0 0 0 0 0 64,171 73.00 73.00 07300 PRISO CHARGED TO PATIENTS 0 0 0 0 0 841,988 161,104 73.00 07300 PRISO CHARGED TO PATIENTS 0 0 0 0 0 841,988 161,104 73.00 07400 RENAL DI ALYSI S 0 30,770 24,500 0 11,615 74.00 07400 RENAL DI ALYSI S 0 30,770 24,500 0 11,615 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 88.01	60. 00 06000 LABORATORY	<i>'</i>	ol	61, 042	2	o	227, 792 ¹	60.00
69.00 06-900 ELECTROCARDIOLOGY 0 5,721 0 0 26,602 69,00 71.00 071.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 89,032 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 841,988 161,104 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 07400 REVALD DALYSIS 0 30,770 24,506 0 11,615	65. 00 06500 RESPIRATOR	RY THERAPY	o	36, 513	0	0	11, 128	65. 00
69.00 06900 ELECTROCARDIOLOGY 0 5,721 0 0 26,602 69,00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 89,032 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 841,988 161,104 73.00 07400 REVALD LALYSIS 0 30,770 24,506 0 11,615 **OUTPATIENT SERVICE COST CENTERS*** **B8.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88.01 88.01 08801 RURAL HEALTH CLINIC 1 0 0 0 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC 1 0 0 0 0 0 0 0 88.03 88.03 08803 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL T	HERAPY	ol	81, 419	0	0	97, 521	66. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 66,171 72. 00 72. 00 72.00 10PL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 66,171 72. 00 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 30,770 24,506 0 11,615 74. 00			l ol			o	26, 602	69. 00
72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 0 0 66, 171 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 30, 770 24, 506 841, 988 161, 104 73. 00 73. 00 07400 RENAL DIALYSIS 0 30, 770 24, 506 841, 988 161, 104 73. 00 74. 00 07400 RENAL DIALYSIS 0 30, 770 24, 506 841, 988 161, 104 73. 00 88. 00 88. 00 RENAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 88. 00 0800 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 0 88. 00 88			ol	0	0	o		71. 00
73.00 07300 RRIGS CHARGED TO PATIENTS 0 0 0 0 841, 988 161, 104 73.00 74.00 07400 RRNAL DIALYSIS 0 30,770 24,506 0 11,615 88. 01 08800 RIVAL HEALTH CLINIC 0 0 0 0 0 0 88. 01 08801 RIVAL HEALTH CLINIC 11 0 0 0 0 0 0 88. 02 08802 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 88. 02 08802 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 88. 03 08803 RIVAL HEALTH CLINIC 11 0 0 0 0 0 0 88. 04 08804 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 88. 05 08804 RURAL HEALTH CLINIC 1 0 0 0 0 0 88. 04 08804 RURAL HEALTH CLINIC 1 0 0 0 0 0 88. 05 08805 RURAL HEALTH CLINIC 1 0 0 0 0 0 88. 04 08804 RURAL HEALTH CLINIC 1 0 0 0 0 0 88. 05 08805 RURAL HEALTH CLINIC 1 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 90. 01 04951 CHEMO/PAIN 0 155, 120 0 0 11, 250 90. 01 04951 CHEMO/PAIN 0 155, 596 125, 236 0 36, 912 90. 03 09003 SLEEP LAB 0 0 5, 545 6, 141 0 4,604 90. 05 09004 BEHAVI ORAL HEALTH CLINIC 0 0 0 0 0 90. 05 09004 BEHAVI ORAL HEALTH CLINIC 0 0 0 0 90. 05 09004 BEHAVI ORAL HEALTH CLINIC 0 0 0 0 91. 00 09100 EMERGENCY 0 145, 516 106, 147 0 83, 079 92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 794, 860 841, 988 1, 561, 386 118. 00 NONNEH BURSABLE COST CENTERS 0 0 5, 269 0 0 192, 01 119. 00 19200 PKYSI CLIANS PRI VATE OFFICES 0 0 5, 269 0 0 192, 01 129. 01 19200 PKYSI CLIANS PRI VATE OFFICES 0 0 5, 269 0 0 192, 01 120. 01 19200 NAL CLINIC O 0 0 0 0 0 0 0 120. 00 00 Cross Foot Adjustments 0 0 0 0 0 0 120. 00 00 00 00 00 00 0 0			ol.	0	0	0		
74. 00 07400 RENAL DI ALYSIS 0 30,770 24,506 0 11,615 74. 00 0 0 0 0 0 0 0 0 0			ol.	0	0	841. 988		
OUTPAT_LENT_SERVICE_COST_CENTERS OUTPAT_LENT_SE	1 1		l l	30, 770	24, 506	0		
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 0 88. 02 88. 02 08802 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 0 0 88. 02 08803 RURAL HEALTH CLINIC 1V 0 0 0 0 0 0 0 0 88. 03 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 0 88. 05 08805 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 88. 05 08805 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 89. 05 08805 RURAL HEALTH CLINIC V 0 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 01 04951 CHEMO/PAIN 0 150, 596 125, 236 0 36, 912 90. 00 90. 02 09002 SENIOR CARE 0 5,545 6,141 0 4,664 90. 01 90. 03 09003 SLEEP LAB 0 0 0 0 0 0 0 0 90. 04 09001 ORTHOPEDICS 0 81,644 0 0 0 7,005 90. 00 90. 05 09004 BEHAVI ORAL HEALTH CLINIC 0 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 145,516 106,147 0 83,079 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 145,516 106,147 0 83,079 91. 00 95. 00 09500 AMBULANCE SERVI CES 0 89,920 95,866 0 0 96. 00 96. 00 09600 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 96. 00 96. 00 09600 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 96. 00 9700 0000 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 0 9800 0000 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 99. 00 0000 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 0 9000 0000 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 9000 0000 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 9000 0000 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 9000 0000 DURABLE MEDICAL EQUIP RENTED 0 0 0 0 0 0 9000 0000 DURABLE MEDICAL FOR SANDLE COST CENTERS 0 0 0 0 0 0 9000 0000 DURABLE MEDICAL FOR SANDLE COST CENTERS 0 0 0 0 0 0			-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-1		
88. 01 08801 RURAL HEALTH CLINIC II			O	0	0	0	0	88. 00
88. 02 08802 RURAL HEALTH CLINIC III			ol	0	0	o	0	
88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 0 88. 03 88. 04 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 88. 04 88. 05 08805 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 0 88. 05 90. 00 09000 CLINIC V 0 0 0 0 0 0 0 11, 250 90. 00 90. 01 04951 CHEMO/PAIN 0 0 150, 596 125, 236 0 36, 912 90. 01 90. 01 04951 CHEMO/PAIN 0 0 150, 596 125, 236 0 36, 912 90. 01 90. 02 09002 SENIOR CARE 0 0 5, 545 6, 141 0 4, 604 90. 02 90. 03 09003 SLEEP LAB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1		ol	0	0	o	0	88. 02
88. 04 08804 RURAL HEALTH CLINIC V			ol.	0	0	0	-	
88. 05 08805 RURAL HEALTH CLINIC VI			ol.	0	0	0	-	
90. 00 09000 CLI NI C 0 55, 120 0 0 11, 250 90. 00 90. 01 04951 CHEMO/PAI N 0 150, 596 125, 236 0 36, 912 90. 02 09002 SENI OR CARE 0 5, 545 6, 141 0 4, 604 90. 02 90. 03 09003 SLEEP LAB 0 0 0 0 0 0 90. 04 09001 ORTHOPEDI CS 0 81, 644 0 0 0 7, 005 90. 05 09004 BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 0 91. 00 09100 EMERGENCY 0 145, 516 106, 147 0 83, 079 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 09500 AMBULANCE SERVI CES 0 89, 920 95, 866 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P RENTED 0 0 0 0 0 0 913. 00 113.00 NTEREST EXPENSE 113.00 11300 NTEREST EXPENSE 113.00 11300 NTEREST EXPENSE 113.00 11200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 01 192. 01 19202 HOME HEALTHCARE SVC 0 0 0 0 0 0 192. 01 192. 02 19201 NAL CLI NI C 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00 0 Negative Cost Centers 0 0 0 0 0 0 201. 00 0 Negative Cost Centers 0 0 0 0 0 201. 00 0 Negative Cost Centers 0 0 0 0 0 201. 00 0 Negative Cost Centers 0 0 0 0 0 201. 00 0 Negative Cost Centers 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00			أم	0		0	-	
90. 01			أم	55 120		0	-	
90. 02		1				0		
90. 03						0		
90. 04 09001 ORTHOPEDI CS 0 081, 644 0 0 0 7, 005 90. 04 90. 05 09004 BEHAVI ORAL HEALTH CLINI C 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 145, 516 106, 147 0 83, 079 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 0THER REI MBURSABLE COST CENTERS 0 89, 920 95, 866 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P RENTED 0 0 0 0 0 0 96. 00 SPECI AL PURPOSE COST CENTERS 113. 00 113. 00 INTEREST EXPENSE 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 058, 907 1, 469, 115 794, 860 841, 988 1, 561, 386 118. 00 NONREI MBURSABLE COST CENTERS 0 0 5, 269 0 0 192. 00 192. 01 19202 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 192. 01 19202 19201 NAL CLINI C 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 Oscillators 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 Oscillators 0 0 0 0 0 201. 00 Oscillators 0 0 0 201. 00 Oscillators 0 0 0 0 201. 00 Oscillators 0 0 201. 00 Oscillators 0 0 0 201. 00 Oscillators 0 0 0 202. 00 Oscillators 0 0 0 203. 00 Oscillators 0 0 0 204. 00 Oscillators 0 0 205. 00 Oscillators 0 0 206. 00 Oscillators 0 0 207.				0, 0.0	0,	0		
90. 05		cs l	ol.	81. 644	. 0	0	-	
91. 00 09100 EMERGENCY 0 145, 516 106, 147 0 83, 079 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 0 89, 920 95, 866 0 0 0 95. 00 96. 00 ODURABLE MEDI CAL EQUI P RENTED 0 0 0 0 0 0 96. 00 ODURABLE MEDI CAL EQUI P RENTED 0 0 0 0 0 0 0 96. 00 ODURABLE MEDI CAL EQUI P RENTED 113. 00 ODURABLE MEDI CAL EQUI P RENTED 0 0 0 0 0 0 0 0 0	1 1		o	0.,011		0		
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			o	145, 516	106, 147	0		
OTHER REI MBURSABLE COST CENTERS 95.00 95,866 0 0 0 95.00	1 1	ON BEDS (NON-DISTINCT PART)	٩		100, 117	Ĭ	30, 0, ,	
95. 00			<u> </u>		1			
96. 00 09600 DURABLE MEDI CAL EQUI P RENTED 0 0 0 0 0 0 0 0 0			0	89, 920	95, 866	0	0	95. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,058,907 1,469,115 794,860 841,988 1,561,386 118.00 NONREI MBURSABLE COST CENTERS 0 0 5,269 0 0 192.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192.01 19202 19201 HEALTHCARE SVC 0 0 0 0 0 192.01 192.02 19201 NAL CLI NI C 0 0 0 0 0 192.02 19201 OUS FOOT Adjustments 200.00 19201 Negative Cost Centers 0 0 0 0 0 0 201.00 19201 100			l l					
113. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-1	-		-1	-	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1,058,907 1,469,115 794,860 841,988 1,561,386 118.00								113. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 5, 269 0 0 192. 00 192. 01 19202 HOME HEALTHCARE SVC 0 0 0 0 0 192. 01 192. 02 19201 NAL CLI NI C 0 0 0 0 0 192. 02 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 201. 00 0 0 201. 00 0 201. 00 0 0 201. 00			1 058 907	1 469 115	794 860	841 988	1 561 386	
192. 00			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,	,		1,7001,7000	
192. 01 19202 HOME HEALTHCARE SVC 0 0 0 0 192. 01 192. 02 19201 NAL CLINIC 0 0 0 0 192. 02 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00			0	0	5. 269	ol	0	192. 00
192. 02 19201 NAL CLINIC 0 0 0 192. 02 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00			1	0		ol		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			l l	0		ol		
201.00 Negative Cost Centers 0 0 0 0 201.00				· ·	1	Ĭ	١	
		,	n	Λ		n	٥	
			1, 058, 907	1, 469, 115	800. 129	841. 988		
	1.1		, , , , , , , , , , , , , , , , , , , ,	,,	,/	3 , . 50	, 22., 200	

Health Financial Systems	PARIS COMMUNIT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 14-1320 Pe Fr To	eriod: com 01/01/2023	Worksheet B Part I Date/Time Pre 5/23/2024 4:0	pared:
Cost Center Description	SOCI AL SERVI CE		Intern & Residents Cost & Post Stepdown Adjustments	Total	37 237 2024 4. 0	Pin
CENEDAL SEDVICE COST CENTEDS	17. 00	24. 00	25. 00	26. 00		
GENERAL SERVI CE COST CENTERS						1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	21, 465					17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	21, 465	12 102 002	0	12, 102, 803		20.00
30. 00 03000 ADULTS & PEDIATRICS ANCILIARY SERVICE COST CENTERS	21, 400	12, 102, 803	0	12, 102, 803		30.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC III 88. 02 08802 RURAL HEALTH CLINIC III 88. 03 08803 RURAL HEALTH CLINIC IV 88. 04 08804 RURAL HEALTH CLINIC IV 88. 05 08805 RURAL HEALTH CLINIC V 90. 01 04951 CHEMO/PAIN 90. 02 09002 SENIOR CARE 90. 03 09003 SLEEP LAB 90. 04 09001 DEMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 804, 991 1, 235, 396 7, 531, 052 4, 934, 046 1, 527, 673 6, 245, 653 308, 158 10, 671, 886 5, 110, 261 7, 634, 281 1, 315, 585 16, 812, 009 867, 190 886, 844 4, 271, 563 854, 449 1, 622 1, 192, 871 5, 086, 792 981, 709 0 1, 222, 501 88, 550 7, 512, 124	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 804, 991 1, 235, 396 7, 531, 052 4, 934, 046 1, 527, 673 6, 245, 653 308, 158 10, 671, 886 5, 110, 261 7, 634, 281 1, 315, 585 16, 812, 009 867, 190 886, 844 4, 271, 563 854, 449 1, 622 1, 192, 871 5, 086, 792 981, 709 0 1, 222, 501 88, 550 7, 512, 124		50. 00 53. 00 54. 00 60. 00 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 74. 00 88. 01 88. 02 88. 03 88. 04 88. 05 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	0	2 07/ 505		2 074 505		
96.00 09600 DURABLE MEDICAL EQUIP RENTED	0	2, 976, 585 12, 893		2, 976, 585 12, 893		95. 00 96. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	21, 465	105, 189, 487	0	105, 189, 487		113. 00 118. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19202 HOME HEALTHCARE SVC 192.02 19201 NAL CLINIC 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 0 0 0 21, 465	8, 912, 633 702, 990 954, 317 0 115, 759, 427	0 0 0 0	8, 912, 633 702, 990 954, 317 0 0 115, 759, 427		192. 00 192. 01 192. 02 200. 00 201. 00 202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Peri od: | Peri Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1320

				10	12/31/2023	5/23/2024 4:0	
			CAPI TAL REI	ATED COSTS		072072021 1.0	ı pııı
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		05 (05	40.445	40.770	40.770	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	25, 625		43, 770	43, 770	4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	0	564, 838		964, 791	7, 028	5. 01
5. 02	00700 OPERATION OF PLANT	0	90, 947		155, 345	2, 445	5. 02
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE		327, 878		560, 044 45, 848	1, 469 0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG		26, 842			-	9. 00
10.00	01000 DI ETARY		18, 880 84, 810		32, 249 144, 863	1, 290 375	10. 00
11. 00	01100 CAFETERI A		38, 590		65, 915	627	11. 00
13. 00	01300 NURSING ADMINISTRATION		38, 148		65, 160	412	13. 00
15. 00	01500 PHARMACY		24, 077		41, 126	464	
16. 00	01600 MEDICAL RECORDS & LIBRARY		61, 672		105, 341	813	
17. 00	01700 SOCIAL SERVICE		4, 312		7, 366	0	17. 00
.,, 00	INPATIENT ROUTINE SERVICE COST CENTERS	91	1,012	3, 55 1	,, 000		17.00
30.00	03000 ADULTS & PEDIATRICS	0	387, 174	274, 152	661, 326	5, 537	30. 00
	ANCILLARY SERVICE COST CENTERS	,	,		, , , ,	,	
50.00	05000 OPERATI NG ROOM	0	388, 970	275, 424	664, 394	3, 654	50. 00
53.00	05300 ANESTHESI OLOGY	o	3, 290	2, 329	5, 619	1, 199	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	203, 594	144, 162	347, 756	2, 996	54.00
60.00	06000 LABORATORY	0	84, 838	60, 072	144, 910	1, 269	60.00
65.00	06500 RESPI RATORY THERAPY	0	10, 532	7, 458	17, 990	759	65.00
66. 00	06600 PHYSI CAL THERAPY	0	647, 051	458, 162	1, 105, 213	1, 692	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	14, 485	10, 257	24, 742	119	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	640	74. 00
00 00	OUTPATIENT SERVICE COST CENTERS	l ol	0		ام	0	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC I		0 41 44E		70 924	0	88. 00 88. 01
88. 02	08802 RURAL HEALTH CLINIC III		41, 465	29, 361	70, 826	0	88. 01 88. 02
88. 03	08803 RURAL HEALTH CLINIC IV		301, 396	213, 414	514, 810	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V		43, 981	31, 142	75, 123	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI		43, 701		73, 123	0	88. 05
90.00	09000 CLINIC		17, 001	12, 038	29, 039	1, 146	90.00
90. 01	04951 CHEMO/PAI N		42, 681	30, 222	72, 903	3, 130	90. 01
90. 02	09002 SENI OR CARE		0		0	115	90. 02
90. 03	09003 SLEEP LAB	l ol	0		o	0	90. 03
90. 04	09001 ORTHOPEDI CS	0	50, 947	36, 075	87, 022	1, 697	90. 04
90. 05	09004 BEHAVIORAL HEALTH CLINIC	o	11, 831	8, 378	20, 209	0	90. 05
91.00	09100 EMERGENCY	0	142, 474	100, 884	243, 358	3, 025	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				o		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	0		0		95. 00
96.00	09600 DURABLE MEDICAL EQUIP RENTED	0	0	0	0	0	96. 00
	SPECIAL PURPOSE COST CENTERS			,	1		
	11300 INTEREST EXPENSE						113. 00
118.00		0	3, 698, 329	2, 618, 729	6, 317, 058	43, 770	118. 00
40-	NONREI MBURSABLE COST CENTERS			T			400
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19202 HOME HEALTHCARE SVC	0	0	0	0		192. 01
	19201 NAL CLINIC	0	60, 290	42, 691	102, 981	0	192. 02
200. 00 201. 00			^		0	0	200. 00 201. 00
201.00		o	7 7EO 410	0 2, 661, 420	6, 420, 039	43, 770	
202. UL	TOTAL (Sum TITIES TTO LINGUIGHT 201)	١	3, 758, 619	2,001,420	0, 420, 039	43, 770	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Peri od: | Peri Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1320

				1	0 12/31/2023	5/23/2024 4: 0	
	Cost Center Description	ADMI NI STRATI VE	ADMI TTI NG	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	'	AND GENERAL		PLANT	LINEN SERVICE		
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			T			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	074 040					4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL	971, 819	040.040				5. 01
5. 02	00560 ADMITTING	60, 278	218, 068				5. 02
7.00	00700 OPERATION OF PLANT	37, 001	0	598, 514			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 726	0	6, 953		F. 000	8. 00
9.00	00900 HOUSEKEEPI NG	18, 393	0	4, 891	0		1
10.00	01000 DI ETARY	6, 864	0	21, 968		_,	1
11.00	01100 CAFETERI A	11, 411	0	9, 996		923	1
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 640	0	9, 881	0	913	
15. 00	01500 PHARMACY	6, 306	0	-,	0		1
16.00	01600 MEDI CAL RECORDS & LI BRARY	11, 306	0				1
17. 00	01700 SOCIAL SERVICE	77	0	1, 117	0	103	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	66, 558	35, 225	100, 289	54, 527	9, 261	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	00, 336	30, 220	100, 269	34, 327	9, 201	30.00
50. 00	05000 OPERATI NG ROOM	15, 211	8, 191	100, 755	O	9, 304	50.00
53. 00	05300 ANESTHESI OLOGY	9, 483	0, 171				1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	47, 783	22, 476	•			
60. 00	06000 LABORATORY	32, 247	17, 087				1
65. 00	06500 RESPI RATORY THERAPY	10, 368	6, 531			252	
66. 00	06600 PHYSI CAL THERAPY	31, 041	16, 045			15, 478	
69. 00	06900 ELECTROCARDI OLOGY	1, 749	797			346	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	79, 717	33, 013			0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	42, 345	00,010		l .		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	48, 485	25, 988				1
74. 00	07400 RENAL DI ALYSI S	10, 483	0		1		1
	OUTPATIENT SERVICE COST CENTERS				- 1		
88. 00	08800 RURAL HEALTH CLINIC	141, 165	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	7, 280	0	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	7, 445	0	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	35, 859	0	0	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	7, 173	0	0	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	14	0	0	0	0	88. 05
90.00	09000 CLI NI C	8, 043	4, 632	0	0	407	90. 00
90. 01	04951 CHEMO/PAI N	36, 120	13, 105	0	0	1, 021	90. 01
90. 02	09002 SENI OR CARE	7, 014	3, 947	0	0	0	90. 02
90. 03	09003 SLEEP LAB	0	0	1	· ·	0	
90. 04	09001 ORTHOPEDI CS	8, 039	3, 902		1	1, 219	
90. 05	09004 BEHAVI ORAL HEALTH CLINIC	187	990			283	1
91. 00	09100 EMERGENCY	49, 626	26, 139	36, 905	0	3, 408	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					L	92. 00
	OTHER REIMBURSABLE COST CENTERS	00.400					
95. 00	09500 AMBULANCE SERVICES	23, 428	0	•		l	
96. 00	09600 DURABLE MEDICAL EQUIP RENTED SPECIAL PURPOSE COST CENTERS	108	0	0	0	0	96. 00
112 00				I			112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	885, 973	218, 068	567, 681	54, 527	52 074	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	000, 773	210,000	307,001	54, 527	33, 770	1110.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	73, 373	0	15, 216	O	1 405	192. 00
	19202 HOME HEALTHCARE SVC	5, 902	0				192. 00
	19201 NAL CLINIC	6, 571	0		· ·		192. 02
200.00]	O	10, 317		1, 142	200. 00
201.00			0	0	0	0	201. 00
202.00		971, 819	218, 068				202. 00
			-,				

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1320

				To	12/31/2023	Date/Time Pre 5/23/2024 4:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	ı pili
	oust defiter bescription	DIETAKI	OALLIERIA	ADMI NI STRATI ON	THANNAGT	RECORDS &	
						LI BRARY	
		10.00	11. 00	13.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00560 ADMITTING						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	17/ 000					9.00
10.00	01000 DI ETARY 01100 CAFETERI A	176, 099	00 070				10.00
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	0	88, 872 1, 198				11. 00 13. 00
15. 00	01500 PHARMACY	0	1, 140	1	56, 061		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		2, 367	1	0	137, 277	16.00
17. 00	01700 SOCIAL SERVICE		2, 307		Ö	0	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	9		<u> </u>	<u> </u>		17.00
30. 00	03000 ADULTS & PEDIATRICS	176, 099	16, 109	27, 536	0	3, 889	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	10, 636	17, 903	0	23, 622	50.00
53.00	05300 ANESTHESI OLOGY	0	3, 491	0	0	3, 408	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	8, 720	1	0	33, 066	1
60.00	06000 LABORATORY	0	3, 693	1	0	20, 023	1
65.00	06500 RESPI RATORY THERAPY	0	2, 209	1	0	978	1
66.00	06600 PHYSI CAL THERAPY	0	4, 926	1	0	8, 572	1
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	346 0	1	0	2, 338 7, 826	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5, 816	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		56, 061	14, 161	73.00
74. 00	07400 RENAL DIALYSIS	o	1, 862		0	1, 021	74. 00
	OUTPATIENT SERVICE COST CENTERS	- 1	,	,	- 1	, -	
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0	0	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	2 225	0	0	0	88. 05
90. 00 90. 01	09000 CLI NI C 04951 CHEMO/PAI N	0	3, 335	1	0	989	90. 00 90. 01
90.01	09002 SENI OR CARE	0	9, 111 335	1	0	3, 245 405	90.01
90. 02	09003 SLEEP LAB		0	1		0	90.02
90. 04	09001 ORTHOPEDI CS	o o	4, 939	_	0	616	90. 04
90. 05	09004 BEHAVI ORAL HEALTH CLINIC	o	0	o	o	0	90. 05
91.00	09100 EMERGENCY	O	8, 803	11, 038	0	7, 302	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	5, 440	9, 969	0	0	95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P RENTED	0	0	0	0	0	96. 00
440.00	SPECIAL PURPOSE COST CENTERS			1			
	11300 I NTEREST EXPENSE	47/ 000	00.070	00 (5)	F/ 0/4	407.077	113. 00
118. 00		176, 099	88, 872	82, 656	56, 061	137, 277	1118.00
102 00	NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES	0	0	548	ol	^	192. 00
	19200 PHYSICIANS PRIVATE OFFICES		0	1	0		192. 00
	19201 NAL CLINIC		0	0	0		192. 01
200.00	1 1		O		٩	O	200. 00
201.00		o	0	О	0	0	201. 00
202.00		176, 099	88, 872		56, 061	137, 277	
	- ,			,			

Heal th	Financial Systems	PARIS COMMUNIT	Y HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der Co	CN: 14-1320 P	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/23/2024 4:01 pm
	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
		17. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS	1				
16.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE AND GENERAL 00560 ADMITTING 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	8, 663				1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	2,222				
30.00	03000 ADULTS & PEDIATRICS	8, 663	1, 165, 019	0	1, 165, 019	30.00
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATI NG ROOM	0	853, 670	1		50.00
53. 00 54. 00	05300 ANESTHESI OLOGY	0	24, 131	1		53.00
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	520, 404 243, 233	1		54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY		41, 815	1	l	65. 00
66. 00	06600 PHYSI CAL THERAPY		1, 350, 572	1	1, 350, 572	66.00
	06900 ELECTROCARDI OLOGY	o	34, 189		34, 189	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	120, 556		l	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	48, 161	0	48, 161	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	144, 695	1		73. 00
74. 00	07400 RENAL DIALYSIS	0	16, 554	1 0	16, 554	74. 00
00.00	OUTPATIENT SERVICE COST CENTERS		444.47	-	444 445	
88. 00	08800 RURAL HEALTH CLINIC	0	141, 165	1		88. 00
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	0	78, 106 7, 445	1		88. 01 88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	550, 669		I	88. 03
88. 04	08804 RURAL HEALTH CLINIC V		82, 296	1		88. 04
88. 05	08805 RURAL HEALTH CLINIC VI		14			88. 05
90.00	09000 CLI NI C	O	47, 591		l .	90.00
90. 01	04951 CHEMO/PAI N	0	151, 658	0	151, 658	90. 01
90. 02	09002 SENI OR CARE	0	12, 455	0	12, 455	90. 02
90. 03	09003 SLEEP LAB	0	0	0	0	90. 03
	09001 ORTHOPEDI CS	0	107, 434	1		90. 04
	09004 BEHAVI ORAL HEALTH CLINIC	0	24, 734			
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	389, 604	0 0		91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS			1 0		92.00
95. 00	09500 AMBULANCE SERVICES	0	40, 706	0	40, 706	95. 00
	09600 DURABLE MEDICAL EQUIP RENTED	l ol	108			
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			1	
113. 00 118. 00		8, 663	6, 196, 984	0	6, 196, 984	113. 00 118. 00
102.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CLANS' PRI VATE OFFI CES	0	90, 542) 0	90, 542	192. 00
	19200 PHYSICIANS PRIVATE OFFICES 19202 HOME HEALTHCARE SVC		90, 542 5, 902	l .		192. 00
	19201 NAL CLINIC		126, 611	1		192. 02
200.00	l l	1	120, 011		I	200. 00
201.00		0	0	o o	l .	201. 00
202.00		8, 663	6, 420, 039	o o	6, 420, 039	202. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1320 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** FIXT **FOULP** BENEFITS AND GENERAL (SQUARE (SOUARE DEPARTMENT (ACCUM. COST) FEET) FEET) (GROSS SALARI ES) 1.00 2.00 5A. 01 5. 01 GENERAL SERVICE COST CENTERS 1 00 135 968 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 135, 968 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 927 927 37, 256, 075 4.00 00590 ADMINISTRATIVE AND GENERAL 20. 433 5, 986, 416 5 01 -14, 203, 476 101 555 951 5 01 20 433 5.02 00560 ADMITTING 3, 290 3, 290 2, 081, 253 0 6, 299, 291 5.02 11, 861 11, 861 7.00 00700 OPERATION OF PLANT 1, 249, 995 3, 866, 766 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 971 971 0 180, 368 8.00 0 1, 098, 044 00900 HOUSEKEEPI NG 1, 922, 112 9 00 9 00 683 683 10.00 01000 DI ETARY 3,068 3,068 319, 366 0 717, 301 10.00 01100 CAFETERI A 1, 396 533, 392 0 1, 192, 539 11.00 1, 396 11.00 0 01300 NURSING ADMINISTRATION 1, 380 350, 255 589, 369 13.00 13.00 1,380 15.00 01500 PHARMACY 871 871 395. 181 658, 982 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 2, 231 2, 231 692, 160 0 1, 181, 549 16.00 01700 SOCIAL SERVICE 0 17.00 156 156 8, 068 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14,006 14,006 4, 712, 091 0 6, 955, 617 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 071 14, 071 3, 109, 816 0 1, 589, 654 50.00 53.00 05300 ANESTHESI OLOGY 1,020,800 0 990, 961 53.00 119 119 0 4, 993, 477 54.00 05400 RADI OLOGY-DI AGNOSTI C 7.365 7.365 2, 549, 839 54 00 06000 LABORATORY 3,069 3, 069 1,079,793 3, 369, 943 60.00 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 381 381 645, 895 1, 083, 514 65.00 66.00 06600 PHYSI CAL THERAPY 23.407 23, 407 1, 440, 249 3, 243, 899 66,00 69.00 06900 ELECTROCARDI OLOGY 524 524 101, 202 182, 829 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 8, 330, 771 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 4, 425, 188 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 5, 066, 890 73.00 07400 RENAL DIALYSIS 1, 095, 481 74.00 0 544, 301 74.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 14, 749, 232 88.00 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC II 1,500 1,500 760, 787 88.01 08802 RURAL HEALTH CLINIC III 0 88.02 0 778,030 88.02 08803 RURAL HEALTH CLINIC IV 10, 903 10, 903 0 3, 747, 449 88.03 88.03 08804 RURAL HEALTH CLINIC V 0 749, 609 88.04 1, 591 1, 591 88 04 0 88.05 08805 RURAL HEALTH CLINIC VI 0 1, 423 88.05 90.00 09000 CLI NI C 615 615 975, 046 0 840, 512 90.00 3, 774, 640 04951 CHEMO/PAIN 2, 663, 946 90 01 90 01 1 544 1.544 09002 SENIOR CARE 90.02 0 C 98, 094 732, 947 90.02 90.03 09003 SLEEP LAB 0 0 90.03 09001 ORTHOPEDI CS 0 90.04 1,843 1,843 1, 444, 228 840, 128 90.04 90 05 09004 BEHAVIORAL HEALTH CLINIC 90 05 428 19, 549 428 91.00 09100 EMERGENCY 5, 154 5, 154 2, 574, 090 5, 186, 088 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS

0 0 1, 590, 623 0 2, 4	48, 372 95. 00
	11, 311 96. 00
	113. 00
117) 133, 787 133, 787 37, 256, 075 -14, 203, 476 92, 5	84, 646 118. 00
0 0 7, 6	67, 827 192. 00
	16, 734 192. 01
2, 181 2, 181 0 0 6	86, 744 192. 02
	200. 00
	201. 00
, 3, 758, 619 2, 661, 420 10, 541, 987 14, 2	203, 476 202. 00
	139859 203. 00
43,770	71, 819 204. 00
^t 0. 001175 0.	009569 205. 00
cated	206. 00
	007.00
),	207. 00
2, 181 2, 181 0 0 6 3, 758, 619 2, 661, 420 10, 541, 987 14, 2 rt I) 27. 643409 19. 573870 0. 282960 43, 770 9	192, 744, 192, 202, 203, 476, 202, 139859, 203, 171, 819, 204, 206, 206, 206, 206, 206, 206, 206, 206

	Financial Systems	PARIS COMMUNI	TY HOSPITAL Provider C	CN: 14-1320 P	In Lie	u of Form CMS-2 Worksheet B-1	2552-10
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/23/2024 4:0	
	Cost Center Description	ADMITTING	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, p
		(ACCUM. COST)	PLANT (SQUARE	LINEN SERVICE (PATIENT DAYS)	(SQUARE FEET)	(PATIENT DAYS)	
		5. 02	FEET) 7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	5.02	7.00	8.00	7.00	10.00	
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 ADMINISTRATIVE AND GENERAL						5. 01
5. 02 7. 00	00560 ADMITTING 00700 OPERATION OF PLANT	43, 642, 627	83, 586				5. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	o o	971				8. 00
9.00	00900 HOUSEKEEPI NG	0	683		85, 934	100	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	3, 068 1, 396	1	3, 068 1, 396	100	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	0	1, 380	0	1, 380	0	13. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	871 2, 231		871 2, 231	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	156		156	0	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	7 052 240	14.007	100	14.00/	100	20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	7, 052, 268	14, 006	100	14, 006	100	30. 00
50.00	05000 OPERATING ROOM	1, 639, 159	14, 071		14, 071	0	50. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 4, 497, 846	119 7, 365		119 7, 365	0	53. 00 54. 00
60.00	06000 LABORATORY	3, 419, 474	3, 069		3, 069	0	60.00
65.00	06500 RESPI RATORY THERAPY	1, 306, 888	381		381	0	65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	3, 210, 861 159, 403	23, 407 524		23, 407 524	0	66. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 606, 597	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	5, 200, 726 0	0		0	0	73. 00 74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC I	0	0	•	0	0	88. 00 88. 01
88. 02	08802 RURAL HEALTH CLINIC III	o o	Ö	ő	Ö	Ö	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	88. 03
88. 04 88. 05	08804 RURAL HEALTH CLINIC V 08805 RURAL HEALTH CLINIC VI	0	0	0	0	0	88. 04 88. 05
90.00	09000 CLI NI C	926, 897	0	0	615	0	90. 00
90. 01 90. 02	04951 CHEMO/PAI N 09002 SENI OR CARE	2, 622, 576 789, 929	0	0	1, 544 0	0	90. 01 90. 02
90. 03	09003 SLEEP LAB	0	0	ő	ő	0	90. 03
90. 04 90. 05	09001 ORTHOPEDI CS	780, 815	0		1, 843	0	90. 04 90. 05
	09004 BEHAVI ORAL HEALTH CLINIC 09100 EMERGENCY	198, 168 5, 231, 020			428 5, 154	0	ł
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	O	0	0	O	0	95. 00
	09600 DURABLE MEDICAL EQUIP RENTED	O	0		o	0	96. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118.00		43, 642, 627	79, 280	100	81, 628	100	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1	0.405				
	19200 PHYSICIANS' PRIVATE OFFICES 19202 HOME HEALTHCARE SVC	0	2, 125 0	0	2, 125 0		192. 00 192. 01
192. 02	19201 NAL CLINIC	O	2, 181	1	2, 181	0	192. 02
200. 00 201. 00	1 1						200. 00 201. 00
201.00		7, 180, 304	4, 407, 568	256, 796	2, 226, 952	1, 058, 907	1
202.00	Part I)	0.1/4525	F2 72002/	2 5/7 0/0000	25 014/70	10 500 07000	202.00
203. 00 204. 00		0. 164525 218, 068	52. 730936 598, 514		25. 914679 56, 823	10, 589. 070000 176, 099	
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 004997	7. 160457	545. 270000	0. 661240	1, 760. 990000	205. 00
206.00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)					 	207.00

In Lieu of Form CMS-2552-10 Health Financial Systems PARIS COMMUNITY HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1320 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm Cost Center Description CAFETERI A NURSI NG PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON (GROSS (COST REQU.) RECORDS & SALARI ES) LI BRARY (PAT DAYS) (NRSNG (GROSS CHARGES) SALARI ES) 11.00 13.00 15.00 16.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE FOULP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00590 ADMINISTRATIVE AND GENERAL 5.01 5. 01 00560 ADMITTING 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 25, 987, 609 11.00 13.00 01300 NURSING ADMINISTRATION 350, 255 12, 780, 606 13.00 15.00 01500 PHARMACY 395, 181 100 15.00 01600 MEDICAL RECORDS & LIBRARY 178, 943, 374 16 00 692, 160 16 00 0 17.00 01700 SOCIAL SERVICE 0 100 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 100 30.00 4, 712, 091 4, 229, 695 5, 070, 041 30 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 109, 816 2, 750, 013 30, 797, 538 0 50.00 0 53.00 05300 ANESTHESI OLOGY 1,020,800 0 4, 443, 527 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 43, 076, 651 54 00 54 00 2, 549, 839 Ω 0 60.00 06000 LABORATORY 1,079,793 0 0 26, 104, 984 0 60.00 06500 RESPIRATORY THERAPY 645, 895 1, 275, 301 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 440, 249 0 0 11, 175, 873 0 66, 00 06900 ELECTROCARDI OLOGY 0 3.048,617 69 00 69 00 101, 202 C 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 10, 203, 128 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0 7.583.204 0 72.00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 18. 462. 497 0 73.00 07400 RENAL DIALYSIS 1, 331, 053 544, 301 391, 433 0 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 0 88 00 08801 RURAL HEALTH CLINIC II 0 0 0 88.01 88.01 0 0 08802 RURAL HEALTH CLINIC III 0 0 88 02 Ω 0 Λ 88 02 08803 RURAL HEALTH CLINIC IV 0 0 88.03 88.03 0 88.04 08804 RURAL HEALTH CLINIC V 0 0 88.04 08805 RURAL HEALTH CLINIC VI 0 88.05 88.05 0 C 0 0 90.00 09000 CLI NI C 975, 046 1, 289, 271 0 90.00 90.01 04951 CHEMO/PAI N 2, 663, 946 2,000,419 4, 230, 173 0 90.01 09002 SENI OR CARE 98, 094 98, 094 527, 617 90.02 90.02 09003 SLEEP LAB 0 90.03 90.03 C Λ 90.04 09001 ORTHOPEDI CS 1, 444, 228 C 0 802, 756 90.04 90.05 09004 BEHAVIORAL HEALTH CLINIC 0 90.05 321 09100 EMERGENCY 0 91.00 2, 574, 090 1, 695, 505 9, 520, 822 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 590, 623 1, 531, 287 0 0 n 95.00 09600 DURABLE MEDICAL EQUIP. - RENTED 0 96.00 0 0 96.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 25, 987, 609 100 178, 943, 374 100 118.00 12, 696, 446 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 84, 160 0 0 0 192.00 192. 01 19202 HOME HEALTHCARE SVC 0 0 0 0 192. 01 192. 02 19201 NAL CLINIC 0 0 ol 0 192.02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, 202.00 1, 469, 115 800, 129 841, 988 21, 465 202. 00 1, 561, 386 Part I) 214. 650000 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 8, 419, 880000 0.008726 0.056531 0.062605 204.00 Cost to be allocated (per Wkst. B, 88,872 137, 277 8, 663 204. 00 83, 204 56, 061 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.003420 0.006510 560.610000 0.000767 86. 630000 205. 00 II)l<u>2</u>06. 00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)

207. 00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207.00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1320	Peri od:	Worksheet C
		From 01/01/2023	
		T 40 /04 /0000	D 1 /T' D 1

					From 01/01/2023 To 12/31/2023		pared:
			Title	XVIII	Hospi tal	Cost	, piii
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00	03000 ADULTS & PEDIATRICS	12, 102, 803		12, 102, 80	3 0	0	30. 00
	ANCILLARY SERVICE COST CENTERS		1	1			
50. 00	05000 OPERATING ROOM	3, 804, 991		3, 804, 99		1	
53. 00	05300 ANESTHESI OLOGY	1, 235, 396		1, 235, 39		-	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 531, 052	l .	7, 531, 05		1	1 0 11 00
60.00	06000 LABORATORY	4, 934, 046		4, 934, 04		0	
65.00	06500 RESPI RATORY THERAPY	1, 527, 673	l .	.,,		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 245, 653	0	6, 245, 65	3 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	308, 158		308, 15	8 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 671, 886		10, 671, 88	6 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	5, 110, 261		5, 110, 26	1 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 634, 281		7, 634, 28	1 0	0	73. 00
74.00	07400 RENAL DIALYSIS	1, 315, 585		1, 315, 58	5 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	16, 812, 009		16, 812, 00	9 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	867, 190		867, 19	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	886, 844		886, 84	4 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	4, 271, 563		4, 271, 56	3 0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	854, 449		854, 44	9 0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	1, 622		1, 62	2 0	0	88. 05
90.00	09000 CLI NI C	1, 192, 871		1, 192, 87	1 0	ĺ	90.00
90. 01	04951 CHEMO/PAI N	5, 086, 792		5, 086, 79		0	90. 01
90. 02	09002 SENI OR CARE	981, 709		981, 70		0	90. 02
90. 03	09003 SLEEP LAB	. 0			0 0	0	90. 03
90. 04	09001 ORTHOPEDI CS	1, 222, 501		1, 222, 50	1 0	0	90. 04
90. 05	09004 BEHAVIORAL HEALTH CLINIC	88, 550		88, 55		0	90. 05
91.00	09100 EMERGENCY	7, 512, 124		7, 512, 12		0	91, 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 071, 496		5, 071, 49		0	
72.00	OTHER REIMBURSABLE COST CENTERS	0,071,170		3,0,1,1,	<u> </u>		72.00
95. 00	09500 AMBULANCE SERVI CES	2, 976, 585		2, 976, 58	5 0	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP RENTED	12, 893		12, 89		-	
70.00	SPECIAL PURPOSE COST CENTERS	12,070		12,07	<u> </u>		70.00
113.00	11300 I NTEREST EXPENSE						113.00
200.00		110, 260, 983	0	110, 260, 98	3 0	0	200.00
201.00	,	5, 071, 496	l .	5, 071, 49			201. 00
202.00	1 1	105, 189, 487	l .				202.00
					1		

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1320	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Part I

					-rom 01/01/2023 Γο 12/31/2023	Part I Date/Time Pre 5/23/2024 4:0	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_1		
30. 00		3, 241, 823		3, 241, 82	3		30. 00
	ANCI LLARY SERVI CE COST CENTERS	1			.1		
50. 00		1, 343, 054	29, 454, 484			0. 000000	50.00
53. 00		187, 228	4, 256, 299			0. 000000	53. 00
54. 00		1, 060, 672	42, 015, 979			0. 000000	54. 00
60. 00		1, 020, 800	25, 084, 184			0. 000000	60. 00
65. 00		388, 885	886, 416			0.000000	65. 00
66. 00		679, 689	10, 496, 184			0. 000000	66. 00
69. 00		27, 556	3, 021, 061	3, 048, 61		0. 000000	69. 00
71. 00		603, 752	9, 599, 376			0.000000	71. 00
72. 00		497, 955	7, 085, 249			0.000000	72. 00
73.00		1, 406, 269	17, 056, 228			0.000000	73. 00
74. 00		0	1, 331, 053	1, 331, 05	0. 988379	0.000000	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0	11, 488, 975				88. 00
88. 01		0	857, 901	857, 90°			88. 01
88. 02		0	365, 688				88. 02
88. 03		0	5, 285, 721	5, 285, 72°			88. 03
88. 04		0	1, 403, 565				88. 04
88. 05		0	0)		88. 05
90. 00		30, 238	1, 259, 033			0.000000	90. 00
90. 01		500	4, 229, 673			0. 000000	90. 01
90. 02		0	527, 617	527, 61		0. 000000	90. 02
90. 03		0	0		0.000000	0.000000	90. 03
90. 04		0	802, 756			0. 000000	90. 04
90. 05		0	321	32		0. 000000	90. 05
91. 00		762	9, 520, 060			0.000000	91. 00
92. 00		0	1, 828, 218	1, 828, 21	2. 774011	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		0	2, 397, 346			0.000000	95. 00
96. 00		0	3, 522	3, 52:	2 3. 660704	0.000000	96. 00
	SPECIAL PURPOSE COST CENTERS						
	0 11300 I NTEREST EXPENSE]					113. 00
200. 0		10, 489, 183	190, 256, 909	200, 746, 09:	2		200. 00
201.0							201. 00
202. 0	0 Total (see instructions)	10, 489, 183	190, 256, 909	200, 746, 09	<u>2 </u>		202. 00

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 14-1320	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared:

				10 12/31/2023	5/23/2024 4:0	
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient	·			
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS					30. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	0. 000000				50. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
60.00	06000 LABORATORY	0. 000000				60. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000				66. 00
69. 00		0. 000000				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
74.00	07400 RENAL DIALYSIS	0. 000000				74. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC					88. 00
88. 01	08801 RURAL HEALTH CLINIC II					88. 01
	08802 RURAL HEALTH CLINIC III					88. 02
88. 03	08803 RURAL HEALTH CLINIC IV					88. 03
88. 04	08804 RURAL HEALTH CLINIC V					88. 04
88. 05	08805 RURAL HEALTH CLINIC VI					88. 05
90.00		0. 000000				90.00
90. 01	04951 CHEMO/PAI N	0. 000000				90. 01
90. 02	09002 SENI OR CARE	0. 000000				90. 02
90. 03	09003 SLEEP LAB	0. 000000				90. 03
	09001 ORTHOPEDI CS	0. 000000				90. 04
90. 05	09004 BEHAVI ORAL HEALTH CLINIC	0. 000000				90. 05
91.00	09100 EMERGENCY	0. 000000				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92. 00
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVICES	0. 000000				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP RENTED	0. 000000				96. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113. 00
200.00						200. 00
201.00						201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1320	Peri od:	Worksheet C
		From 01/01/2023	
		T 40 /04 /0000	D 1 /T' D 1

					To 12/31/2023	Date/Time Pre 5/23/2024 4:0	pared:
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)	0.00	2.00	4.00	F 00	
	LAIDATI ENT. DOUTLAIG CEDVA OF COCT. CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10 100 000	ı	10 100 000		40 400 000	
30. 00	03000 ADULTS & PEDIATRICS	12, 102, 803		12, 102, 803	8 0	12, 102, 803	30.00
F0 00	ANCILLARY SERVICE COST CENTERS	0.004.004	ı	0.004.004		0.004.004	F0 00
50.00	05000 OPERATI NG ROOM	3, 804, 991		3, 804, 991		3, 804, 991	
53.00	05300 ANESTHESI OLOGY	1, 235, 396		1, 235, 396		1, 235, 396	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 531, 052		7, 531, 052		7, 531, 052	
60.00	06000 LABORATORY	4, 934, 046		4, 934, 046		4, 934, 046	
65. 00	06500 RESPI RATORY THERAPY	1, 527, 673		.,,		1, 527, 673	
66. 00	06600 PHYSI CAL THERAPY	6, 245, 653	ł .	6, 245, 653		6, 245, 653	
69. 00	06900 ELECTROCARDI OLOGY	308, 158		308, 158		308, 158	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 671, 886		10, 671, 886	0	10, 671, 886	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	5, 110, 261		5, 110, 261	0	5, 110, 261	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 634, 281		7, 634, 281	0	7, 634, 281	73. 00
74.00	07400 RENAL DIALYSIS	1, 315, 585		1, 315, 585	0	1, 315, 585	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	16, 812, 009		16, 812, 009	0	16, 812, 009	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	867, 190		867, 190	0	867, 190	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	886, 844		886, 844	0	886, 844	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	4, 271, 563		4, 271, 563	0	4, 271, 563	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	854, 449		854, 449	0	854, 449	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	1, 622		1, 622	0	1, 622	88. 05
90.00	09000 CLI NI C	1, 192, 871		1, 192, 871	0	1, 192, 871	90.00
90. 01	04951 CHEMO/PAI N	5, 086, 792		5, 086, 792	0	5, 086, 792	90. 01
90. 02	09002 SENI OR CARE	981, 709		981, 709		981, 709	
90. 03	09003 SLEEP LAB	0				0	90. 03
90. 04	09001 ORTHOPEDI CS	1, 222, 501		1, 222, 501	0	1, 222, 501	
90. 05	09004 BEHAVIORAL HEALTH CLINIC	88, 550		88, 550		88, 550	1
91. 00	09100 EMERGENCY	7, 512, 124		7, 512, 124		7, 512, 124	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 071, 496		5, 071, 496		5, 071, 496	
72.00	OTHER REIMBURSABLE COST CENTERS	0,071,170		0,071,170	<u> </u>	0,011,170	72.00
95. 00	09500 AMBULANCE SERVICES	2, 976, 585		2, 976, 585	5 0	2, 976, 585	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP RENTED	12, 893		12, 893		12, 893	
70.00	SPECIAL PURPOSE COST CENTERS	12,073		12,070	,1 0	12, 073	70.00
113 00	11300 I NTEREST EXPENSE						113. 00
200.00	1 1	110, 260, 983	0	110, 260, 983	0	110, 260, 983	
200.00		5, 071, 496	ł .	5, 071, 496		5, 071, 496	
201.00	1	105, 189, 487					
202.00		100, 107, 407	1	105, 107, 467	1	105, 107, 467	1202.00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1320	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				Т	o 12/31/2023	Date/Time Pre 5/23/2024 4:0	
			Title XIX			Cost	ı pııı
			Charges	.=	Hospi tal		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	·	+ col. 7)	Ratio	Inpati ent	
				,		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 241, 823		3, 241, 823	3		30. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 343, 054	29, 454, 484	30, 797, 538		0.000000	
53.00	05300 ANESTHESI OLOGY	187, 228	4, 256, 299	4, 443, 527	0. 278021	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 060, 672	42, 015, 979	43, 076, 651	0. 174829	0.000000	54.00
	06000 LABORATORY	1, 020, 800	25, 084, 184	26, 104, 984	0. 189008	0.000000	60.00
	06500 RESPI RATORY THERAPY	388, 885	886, 416	1, 275, 301		0.000000	
	06600 PHYSI CAL THERAPY	679, 689	10, 496, 184	11, 175, 873	0. 558851	0.000000	66. 00
69.00	06900 ELECTROCARDI OLOGY	27, 556	3, 021, 061	3, 048, 617	0. 101081	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	603, 752	9, 599, 376	10, 203, 128	1. 045943	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	497, 955	7, 085, 249		0. 673892	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 406, 269	17, 056, 228	18, 462, 497	0. 413502	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	1, 331, 053	1, 331, 053	0. 988379	0.000000	74. 00
	OUTPATIENT SERVICE COST CENTERS	.					
	08800 RURAL HEALTH CLINIC	0	11, 488, 975			0.000000	
	08801 RURAL HEALTH CLINIC II	0	857, 901			0.000000	
	08802 RURAL HEALTH CLINIC III	0	365, 688			0.000000	
	08803 RURAL HEALTH CLINIC IV	0	5, 285, 721			0.000000	
	08804 RURAL HEALTH CLINIC V	0	1, 403, 565	1, 403, 565		0.000000	
	08805 RURAL HEALTH CLINIC VI	0	0		0.00000	0.000000	
	09000 CLI NI C	30, 238	1, 259, 033			0.000000	
	04951 CHEMO/PAI N	500	4, 229, 673			0.000000	
	09002 SENI OR CARE	0	527, 617	527, 617		0.000000	
	09003 SLEEP LAB	0	0	(0.00000	0.000000	
	09001 ORTHOPEDI CS	0	802, 756	802, 756		0.000000	
	09004 BEHAVIORAL HEALTH CLINIC	0	321	321	275. 856698	0.000000	90. 05
91.00	09100 EMERGENCY	762	9, 520, 060	9, 520, 822	0. 789021	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 828, 218	1, 828, 218	2. 774011	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	2, 397, 346			0. 000000	
96.00	09600 DURABLE MEDICAL EQUIP RENTED	0	3, 522	3, 522	3. 660704	0.000000	96. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00	, , , , , , , , , , , , , , , , , , , ,	10, 489, 183	190, 256, 909	200, 746, 092	2		200. 00
201.00							201. 00
202.00	Total (see instructions)	10, 489, 183	190, 256, 909	200, 746, 092	2		202. 00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1320	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				10 12/31/2023	5/23/2024 4:01	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient		<u> </u>		
	·	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	•				
30.00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
	OUTPATIENT SERVICE COST CENTERS	•				
88.00	08800 RURAL HEALTH CLINIC	0. 000000				88.00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000				88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000				88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0. 000000				88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0. 000000				88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0. 000000				88. 05
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	04951 CHEMO/PAI N	0. 000000				90. 01
90. 02	09002 SENI OR CARE	0. 000000				90. 02
90. 03	09003 SLEEP LAB	0. 000000				90.03
90.04	09001 ORTHOPEDI CS	0. 000000				90.04
90.05	09004 BEHAVI ORAL HEALTH CLINIC	0. 000000				90.05
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0. 000000				95.00
96.00	09600 DURABLE MEDICAL EQUIP RENTED	0. 000000				96.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 I NTEREST EXPENSE					113. 00
200.00	Subtotal (see instructions)				2	200. 00
201.00	Less Observation Beds				2	201. 00
202.00	Total (see instructions)				2	202. 00

Heal th Financial	Systems		PARIS COMMUNI	TY H	OSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF	INPATIENT ANCILLARY SERVICE	CAPI TAL	COSTS		Provi der (CCN: 14-1320	Per		Worksheet D	
							Fro	m 01/01/2023		
							To	12/31/2023	Date/Time Pre	pared:
									5/23/2024 4:0	1 pm
					Ti tl	e XVIII		Hospi tal	Cost	
Cost	Center Description		Capi tal	Tota	al Charges	Ratio of Cos	st	I npati ent	Capital Costs	
			Related Cost	(fro	m Wkst. C	to Charges		Program	(column 3 x	
			(from Wkst. B,	Par	t I, col.	(col . 1 ÷ co	ıl.	Charges	column 4)	
			Part II, col.		8)	2)		-		
			26)							
			1 00		2 00	2 00		4 00	F 00	

			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATI NG ROOM	853, 670			679, 700	18, 841	50.00
53.00	05300 ANESTHESI OLOGY	24, 131	4, 443, 527	0. 005431	87, 058	473	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	520, 404	43, 076, 651	0. 012081	561, 503	6, 784	54. 00
60.00	06000 LABORATORY	243, 233	26, 104, 984	0. 009317	563, 356	5, 249	60.00
65.00	06500 RESPI RATORY THERAPY	41, 815	1, 275, 301	0. 032788	202, 601	6, 643	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 350, 572	11, 175, 873	0. 120847	372, 821	45, 054	66. 00
69. 00	06900 ELECTROCARDI OLOGY	34, 189	3, 048, 617	0. 011215	15, 953	179	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	120, 556	10, 203, 128	0. 011816	307, 002	3, 628	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	48, 161	7, 583, 204	0. 006351	254, 503	1, 616	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	144, 695	18, 462, 497	0. 007837	700, 249	5, 488	73. 00
74.00	07400 RENAL DIALYSIS	16, 554	1, 331, 053	0. 012437	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	141, 165	11, 488, 975	0. 012287	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	78, 106	857, 901	0. 091043	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	7, 445	365, 688	0. 020359	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	550, 669	5, 285, 721	0. 104180	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	82, 296	1, 403, 565	0. 058634	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	14	0	0.000000	0	0	88. 05
90.00	09000 CLI NI C	47, 591	1, 289, 271	0. 036913	0	0	90.00
90. 01	04951 CHEMO/PAI N	151, 658	4, 230, 173	0. 035851	24	1	90. 01
90. 02	09002 SENI OR CARE	12, 455	527, 617	0. 023606	0	0	90. 02
90. 03	09003 SLEEP LAB	0	1		0	0	90. 03
90. 04	09001 ORTHOPEDI CS	107, 434	802, 756	0. 133831	0	0	90. 04
90.05	09004 BEHAVI ORAL HEALTH CLINIC	24, 734			0	0	90. 05
91.00	09100 EMERGENCY	389, 604	9, 520, 822	0. 040921	251	10	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	488, 182	1, 828, 218	0. 267026	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP RENTED	108	3, 522	0. 030664	0	0	1
200.00	Total (lines 50 through 199)	5, 479, 441	195, 106, 923		3, 745, 021	93, 966	200. 00

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1320		Worksheet D
TUDOUCU COSTS			From 01/01/2023	Part IV

THROUG	SH COSTS				From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/23/2024 4:0	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00) JA	3.00	
50.00	05000 OPERATI NG ROOM	0	0	ol	0	0	50.00
53. 00	05300 ANESTHESI OLOGY	0	Ö		0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö		0 0	0	54.00
60.00	06000 LABORATORY	0	O		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	o		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0)	0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	00.00
88. 01	08801 RURAL HEALTH CLINIC II	0	0)	0 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0		0 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0)	0 0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0		0 0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0		0 0	0	88. 05
90.00	09000 CLINIC	0	0)	0	0	90.00
90. 01	04951 CHEMO/PAI N	0	0)	0	0	90. 01
90. 02	09002 SENI OR CARE	0	0	2	0	0	90. 02
90. 03	09003 SLEEP LAB	0	0	2	0	0	90. 03
90. 04	09001 ORTHOPEDICS	0		2	0	0	90.04
90. 05	09004 BEHAVI ORAL HEALTH CLINIC 09100 EMERGENCY	0		2	0	0	90.05
91.00		0	U	'	0	0	91. 00 92. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				U	0	92.00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP RENTED	0	1			0	
200.00	I I				o o	_	200.00

Health Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/23/2024 4:0	
		Ti tl e	e XVIII	Hospi tal	Cost	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	(from Wkst. C,	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see	
	4.00	5. 00	6. 00	7. 00	instructions) 8.00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATI NG ROOM	0	C		0 30, 797, 538	0.000000	50.00

	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0	0	30, 797, 538	l	
	05300 ANESTHESI OLOGY	0	0	0	4, 443, 527	l	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	43, 076, 651	l	
60. 00	06000 LABORATORY	0	0	0	26, 104, 984	l .	
65. 00	06500 RESPI RATORY THERAPY	0	0	0	1, 275, 301	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	11, 175, 873	0.000000	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	3, 048, 617	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10, 203, 128	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	7, 583, 204	0.000000	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	18, 462, 497	0.000000	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	1, 331, 053	0.000000	74. 00
	OUTPATIENT SERVICE COST CENTERS					•	
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	11, 488, 975	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	857, 901	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	365, 688	0.000000	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	0	5, 285, 721	0. 000000	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0	0	1, 403, 565	0. 000000	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0	0	0	0. 000000	88. 05
90. 00	09000 CLI NI C	0	l o	0	1, 289, 271	0. 000000	90.00
90. 01	04951 CHEMO/PAI N	0	l o	0	4, 230, 173	0.000000	90. 01
90. 02	09002 SENI OR CARE	0	0	0	527, 617	l	90. 02
90. 03	09003 SLEEP LAB	0	0	0	0	0.000000	90. 03
90. 04	09001 ORTHOPEDI CS	0	0	0	802, 756	0. 000000	90. 04
90. 05	09004 BEHAVIORAL HEALTH CLINIC	0	0	0	321	0. 000000	90. 05
91. 00	09100 EMERGENCY	0	0	0	9, 520, 822	•	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1, 828, 218	l e	92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS				17 0207 210	0.00000	72.00
95. 00	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDICAL EQUIP RENTED	0	0	0	3, 522	0. 000000	
200. 00		0	1	_	·	l	200.00
200.00	Trotal (Tries so through 177)	1	١	1	175, 100, 725	I	200.00

	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	PARIS COMMUNIT	Provider C	N 14 1220	Period:	u of Form CMS-1	2552-10	
		WICE DIHER PASS	Provider Co		From 01/01/2023	Worksheet D Part IV		
THRUUG	H COSTS				To 12/31/2023		pared:	
						5/23/2024 4:0		
	Title XVIII Hospital Cost							
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent		
		Ratio of Cost	Program	Program	Program	Program		
		to Charges	Charges	Pass-Through		Pass-Through		
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9		
		7)		x col. 10)		x col . 12)		
		9. 00	10. 00	11. 00	12. 00	13. 00		
	ANCILLARY SERVICE COST CENTERS				_1	_		
50. 00	05000 OPERATING ROOM	0. 000000	679, 700		0	0	50.00	
53. 00	05300 ANESTHESI OLOGY	0. 000000	87, 058		0	0	53. 00	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	561, 503		0	0	54. 00	
60.00	06000 LABORATORY	0. 000000	563, 356		0	0	60.00	
65. 00	06500 RESPI RATORY THERAPY	0. 000000	202, 601		0	0	65. 00	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	372, 821		0	0	66. 00	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	15, 953		0	0	69. 00	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	307, 002		0	0	71. 00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	254, 503		0	0	72. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	700, 249		0	0	73. 00	
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00	
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00	
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01	
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000	0		0	0	88. 02	
88. 03	08803 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88. 03	
88. 04	08804 RURAL HEALTH CLINIC V	0. 000000	0		0 0	0	88. 04	
88. 05	08805 RURAL HEALTH CLINIC VI	0. 000000	0		0 0	0	88. 05	
90.00	09000 CLI NI C	0. 000000	0		0	0	90.00	
90. 01	04951 CHEMO/PAI N	0. 000000	24		0 0	0	90. 01	
90. 02	09002 SENI OR CARE	0. 000000	0		0 0	0	90. 02	
90. 03	09003 SLEEP LAB	0. 000000	0		0 0	0	90. 03	
90. 04	09001 ORTHOPEDI CS	0. 000000	0		0 0	0	90. 04	
90. 05	09004 BEHAVIORAL HEALTH CLINIC	0. 000000	0		0	0	90. 05	
91.00	09100 EMERGENCY	0. 000000	251		0 0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00	
	OTHER RELABILE COST CENTERS				•		1	

0. 000000

0

0

3, 745, 021

95.00 0 96.00 0 200.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

96. 00 09600 DURABLE MEDICAL EQUIP. - RENTED

200.00

From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/23/2024 4:01 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 123549 9, 533, 991 0 50.00 53.00 05300 ANESTHESI OLOGY 0. 278021 1, 115, 691 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 174829 54 00 0 11, 058, 267 54 00 0 06000 LABORATORY 60.00 0.189008 0 6, 317, 052 0 60.00 0 65.00 06500 RESPIRATORY THERAPY 1. 197892 236, 069 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.558851 0 3, 039, 219 0 66.00 06900 ELECTROCARDI OLOGY 0 69.00 0.101081 790, 391 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.045943 2, 800, 495 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0.673892 0 2, 973, 486 0 72.00 07300 DRUGS CHARGED TO PATIENTS 7, 745, 988 73 00 73 00 0 413502 5.586 0 74.00 07400 RENAL DIALYSIS 0.988379 0 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08801 RURAL HEALTH CLINIC II 88.01 88 01 88.02 08802 RURAL HEALTH CLINIC III 88.02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 88. 04 08804 RURAL HEALTH CLINIC V 88. 04 08805 RURAL HEALTH CLINIC VI 88.05 88.05 90.00 09000 CLI NI C 0. 925229 564, 832 90.00 04951 CHEMO/PAI N 1. 202502 767, 855 90.01 90.01 0 0 09002 SENI OR CARE 90.02 90.02 1.860647 523, 334 0 09003 SLEEP LAB 0.000000 90.03 90.03 C 0 90.04 09001 ORTHOPEDI CS 1.522880 0 245, 812 0 0 90.04 09004 BEHAVIORAL HEALTH CLINIC o 90. 05 275. 856698 90.05 09100 EMERGENCY 0. 789021 0 91.00 91.00 2, 102, 737 0 416 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 2. 774011 0 420, 160 Ω 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1. 241617 С 95.00 09600 DURABLE MEDICAL EQUIP. - RENTED 96.00 3.660704 n 96.00 0 Ω 200.00 Subtotal (see instructions) 50, 235, 379 6,002 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

50, 235, 379

6 002

0 202.00

202.00

Net Charges (line 200 - line 201)

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 177, 915 0 50.00 53.00 05300 ANESTHESI OLOGY 310, 186 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 1, 933, 306 54 00 06000 LABORATORY 60.00 1, 193, 973 0 60.00 65. 00 06500 RESPIRATORY THERAPY 282, 785 65.00 1, 698, 471 66.00 06600 PHYSI CAL THERAPY 0 66.00 06900 ELECTROCARDI OLOGY 69.00 79,894 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 929, 158 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 2,003,808 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 73 00 3, 202, 982 2.310 74.00 07400 RENAL DIALYSIS 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88 01 88.02 08802 RURAL HEALTH CLINIC III 88.02 88. 03 08803 RURAL HEALTH CLINIC IV 88.03 88. 04 08804 RURAL HEALTH CLINIC V 88. 04 08805 RURAL HEALTH CLINIC VI 88. 05 88.05 90.00 09000 CLI NI C 522, 599 90.00 04951 CHEMO/PAI N 923, 347 90.01 90.01 09002 SENI OR CARE 90.02 973, 740 0 90.02 09003 SLEEP LAB 0 90.03 90.03 90.04 09001 ORTHOPEDI CS 374, 342 0 90.04 09004 BEHAVIORAL HEALTH CLINIC 90.05 0 90.05 09100 EMERGENCY 91.00 91.00 1,659,104 328 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 165, 528 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP. - RENTED 96.00 96.00 Ω

20, 431, 138

20, 431, 138

2, 638

2, 638

200.00

201.00

202. 00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1320 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/23/2024 4:01 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 123549 932, 049 0 50.00 53.00 05300 ANESTHESI OLOGY 0. 278021 0 100, 901 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 174829 0 54 00 0 1, 639, 762 54 00 0 06000 LABORATORY 0 60.00 0.189008 0 851, 868 0 60.00 65.00 06500 RESPIRATORY THERAPY 1. 197892 30, 456 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.558851 0 0 275. 783 0 66.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0.101081 196, 717 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.045943 0 490, 111 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0.673892 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 842, 064 73 00 73 00 0 413502 Ω 0 74.00 07400 RENAL DIALYSIS 0.988379 0 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88 01 88.02 08802 RURAL HEALTH CLINIC III 88.02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 88. 04 08804 RURAL HEALTH CLINIC V 88. 04 08805 RURAL HEALTH CLINIC VI 88. 05 88.05 90.00 09000 CLI NI C 0. 925229 78, 647 90.00 04951 CHEMO/PAI N 1. 202502 0 90.01 90.01 67, 172 0 09002 SENI OR CARE 90.02 90.02 1.860647 0 0 70 0 09003 SLEEP LAB 0.000000 0 0 90.03 90.03 0 0 90.04 09001 ORTHOPEDI CS 1.522880 0 0 0 90.04 25, 668 09004 BEHAVIORAL HEALTH CLINIC 0 90. 05 275. 856698 90.05 09100 EMERGENCY 0. 789021 0 0 91.00 91.00 501,014 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 2. 774011 0 40, 121 Ω 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1. 241617 0 0 95.00 09600 DURABLE MEDICAL EQUIP. - RENTED 0 96.00 3.660704 n 96.00 C 200.00 Subtotal (see instructions) C 6, 072, 403 0 200. 00 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

0

6, 072, 403

0 202.00

202.00

Net Charges (line 200 - line 201)

				From 01/01/2023 To 12/31/2023	Part V Date/Time Pre 5/23/2024 4:0	
		Ti tl	e XIX	Hospi tal	Cost	or piii
	Co	sts				
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subj ect To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS		_				
50.00 05000 OPERATING ROOM		115, 154				50. 00
53. 00 05300 ANESTHESI OLOGY	C	20,000				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C						54. 00
60. 00 06000 LABORATORY		161, 010	1			60.00
65. 00 06500 RESPI RATORY THERAPY	C	36, 483	1			65. 00
66. 00 06600 PHYSI CAL THERAPY	(C	154, 122				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	19, 884	1			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	512, 628	1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		1			73. 00
74.00 07400 RENAL DIALYSIS		0)			74. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88. 00
88.01 08801 RURAL HEALTH CLINIC II						88. 01
88. 02 08802 RURAL HEALTH CLINIC III						88. 02
88. 03 08803 RURAL HEALTH CLINIC IV						88. 03
88. 04 08804 RURAL HEALTH CLINIC V						88. 04
88. 05 08805 RURAL HEALTH CLINIC VI						88. 05
90. 00 09000 CLI NI C	C	,				90.00
90. 01 04951 CHEMO/PAI N		80, 774				90. 01
90. 02 09002 SENI OR CARE	0	130	1			90. 02
90. 03 09003 SLEEP LAB		0	1			90. 03
90. 04 09001 ORTHOPEDI CS		39, 089	1			90. 04
90. 05 09004 BEHAVI ORAL HEALTH CLINIC		0	1			90. 05
91. 00 09100 EMERGENCY	C					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	C	111, 296	<u> </u>			92. 00
OTHER REIMBURSABLE COST CENTERS	1	\l	T			05.00
95. 00 09500 AMBULANCE SERVICES	C	1				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP RENTED	C		1			96. 00
200.00 Subtotal (see instructions)	C	1	1			200. 00
201.00 Less PBP Clinic Lab. Services-Program	C	ή				201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)		2 241 572	,			202. 00
202.00 Net Charges (Title 200 - Title 201)	1	2, 361, 573	1			1202. UU

Health Financial Systems	PARIS COMMU	NITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT	OPERATI NG COST	Provi der CCN: 14-1320	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prep 5/23/2024 4:01	
		Title XVIII	Hospi tal	Cost	

Title XVIII Hospital Cost				10 12/01/2020	5/23/2024 4: 0	1 pm
NART ALL PROVIDER COMPONENTS			Title XVIII	Hospi tal	Cost	
Inpatient days (including private room days and saing-bed days, excluding newborn) 5,094 1.00		Cost Center Description				
IMPARTIENT DAYS 1.00 Impartient days (including private room days and seing-bed days, excluding newborn) 5.094 1.00 Impartient days (including private room days, excluding wing-bed and newborn days) 3.712 2.00 3.00 2.00					1. 00	
Impatient days (including private room days and saing-bed days, excluding newborn) 5,094 1.00						
Impatient days (including private room days, excluding swing-bed and neeborn days) 3,712 2,00 3,00 Private room days (secularing swing-bed and observation bed days) 17 you have only private room days, 2,000 4,00 5,00 6,00 7,0						
Private room days (excluding swing-bed and observation bed days) 17 you have only private room days 2,000						
do not complete this line. 4. 05 Semi-private room days (sectualing swing-bed and observation bed days) 7. 07 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line) 7. 08 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line) 7. 09 Total swing-bed SM type inpatient days (including private room days) through becember 31 of the cost period (if callendar year, enter 0 on this line) 8. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost period (including type inpatient days) (including private room days) after December 31 of the cost period (including type inpatient days) (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) (see Instructions) 8. 08 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newbord adys) (see Instructions) 8. 09 Swing-bed SMF type inpatient days applicable to the Program (excluding private room days) 10. 00 Swing-bed SMF type inpatient days applicable to title sWIII only (including private room days) 11. 00 Swing-bed SMF type inpatient days applicable to title sWIII only (including private room days) 12. 00 Swing-bed SMF type inpatient days applicable to title sWIII only (including private room days) 13. 00 Swing-bed SMF type inpatient days applicable to title sWIII only (including private room days) 14. 00 Swing-bed SMF type inpatient days applicable to title sWIII only (including private room days) 15. 00 Swing-bed SMF type inpatient days applicable to title sWIII only (including private room days) 16. 00 Swing-bed SMF type inpatient days applicable to swing-bed SMF days	2.00				3, 712	2. 00
Semi-perivate room days (excluding swing-bed and observation bed days) Total swing-bed SR type inpatient days (including private room days) after December 31 of the cost reporting period of reporting period of the cost	3.00		/s). 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		· ·				
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					To 12/31/2023		
			Title	e XVIII	Hospi tal	5/23/2024 4:0 Cost	i pili
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per SDiem (col. 1	Program Days	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
2. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43. 00
	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1 00	
3. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1. 00 1, 547, 880	48. 00
. 01	Program inpatient cellular therapy acquisiti	on cost (Workshe	et D-6, Part		column 1)	0	48. 01
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.01)(see instru	CTI ONS)		5, 065, 784	49. 00
. 00	Pass through costs applicable to Program inp	atient routine s	services (from	m Wkst. D, sum	of Parts I and	0	50. 00
00	III)Pass through costs applicable to Program inp	atient ancillary	services (fi	rom Wkst. D, sı	ım of Parts II	0	51.00
	and IV)	•			-	_	
00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-phy	ysician anesthe	etist, and	0	
	medical education costs (line 49 minus line			,			1
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
00	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	1
	Target amount (line 54 x sum of lines 55, 55					0.00	1
	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	line 56 minus I	ine 53)	0	
	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period e	endina 1996	0 0. 00	
	updated and compounded by the market basket)		·	0 .	0		
00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year o	cost report, up	dated by the	0. 00	60.00
00	Continuous improvement bonus payment (if lin					0	61. 00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x						
00	enter zero. (see instructions)		Ü			0	(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instrud	ctions)			0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +b	21 -E +b.			/12 102	(4.00
<i>J</i> 0	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	nber 31 of the	e cost reportir	ng period (See	613, 103	64.00
00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65. 00
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line	65)(title XVIII	only); for	613, 103	66. 00
00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 21	of the cost row	norting period	0	67. 00
	(line 12 x line 19)	3		·	3 1		
00	Title V or XIX swing-bed NF inpatient routin (line 13×1 ine 20)	e costs after De	ecember 31 of	the cost repor	rting period	0	68. 00
00	Total title V or XIX swing-bed NF inpatient					0	69. 00
00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
	Adjusted general inpatient routine service c	-					71.00
	Program routine service cost (line 9 x line		(1) 44	: 25)			72.00
00	Medically necessary private room cost applic Total Program general inpatient routine serv	•	•	,			73. 00 74. 00
00	Capital-related cost allocated to inpatient	•			art II, column		75. 00
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minu	,	covi don nace:	de)			78.00
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	ıs line 79)		79. 00 80. 00
00	Inpatient routine service cost per diem limi	tati on			- /		81. 00
00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
	Program inpatient ancillary services (see in		"				84. 00
00	Utilization review - physician compensation	(see instruction					85. 00
00	Total Program inpatient operating costs (sum PART IV – COMPUTATION OF OBSERVATION BED PAS		rough 85)				86.00
)					87. 00

1, 704 87. 00 2, 976. 23 88. 00 5, 071, 496 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	PARIS COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-1		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 165, 019	12, 102, 803	0. 09626	0 5, 071, 496	488, 182	90.00
91.00 Nursing Program cost	0	12, 102, 803	0.00000	0 5, 071, 496	0	91.00
92.00 Allied health cost	0	12, 102, 803	0.00000	0 5, 071, 496	0	92.00
93.00 All other Medical Education	0	12, 102, 803	0. 00000	5, 071, 496	0	93. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1320	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/23/2024 4:0	pared:
	Titl∈	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 254, 580		30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 12354			
53. 00 05300 ANESTHESI OLOGY		0. 27802			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17482		98, 167	
50. 00 06000 LABORATORY		0. 18900			
55. 00 06500 RESPI RATORY THERAPY		1. 19789		242, 694	
66. 00 06600 PHYSI CAL THERAPY		0. 55885	372, 821	208, 351	
69. 00 06900 ELECTROCARDI OLOGY		0. 10108			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 04594	13 307, 002	321, 107	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 67389	254, 503		
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 41350		289, 554	
74. 00 07400 RENAL DIALYSIS		0. 98837	79 0	0	74. C
OUTPATIENT SERVICE COST CENTERS					1
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	88.0
88.01 08801 RURAL HEALTH CLINIC II		0.00000		0	88. 0
88.02 08802 RURAL HEALTH CLINIC III		0.00000		0	88. (
88.03 08803 RURAL HEALTH CLINIC IV		0.00000		0	88. 0
8.04 08804 RURAL HEALTH CLINIC V		0.00000		0	88. (
8. 05 08805 RURAL HEALTH CLINIC VI		0.00000		0	88. (
0. 00 09000 CLI NI C		0. 92522			90. (
O. 01 04951 CHEMO/PAI N		1. 20250)2 24	29	90. (
0. 02 09002 SENI OR CARE		1. 86064		0	90. (
0. 03 09003 SLEEP LAB		0.00000		0	90. (
0. 04 09001 ORTHOPEDI CS		1. 52288		0	90.0
PO. 05 09004 BEHAVI ORAL HEALTH CLINIC		275. 85669			90.0
P1. 00 09100 EMERGENCY		0. 78902		198	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 77401	11 0	0	92.0
OTHER REIMBURSABLE COST CENTERS					Į.
5. 00 09500 AMBULANCE SERVICES					95. (
6.00 09600 DURABLE MEDICAL FOULP RENTED		3, 66070	04	0	96.1

3.660704

3, 745, 021

3, 745, 021

1, 547, 880 200. 00

96.00 0

201.00

202. 00

96.00 09600 DURABLE MEDICAL EQUIP. - RENTED

200.00

201.00

202.00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCM Component CC		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre	pared
	Title	V\/	Swing Beds - SNF	5/23/2024 4:0 Cost	1 pm
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS					ļ
0. 00 03000 ADULTS & PEDI ATRI CS					30.0
ANCILLARY SERVICE COST CENTERS 0. 00 05000 OPERATING ROOM		0 1005	10 540	67	٠
I I		0. 12354		67	
3. 00 05300 ANESTHESI OLOGY 4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 27802 0. 17482		2, 172	
4. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 00 06000 LABORATORY	+	0. 17482		2, 172 5, 964	1
5. 00 06500 RESPI RATORY THERAPY	1	1. 19789		14, 717	
5. 00 06600 PHYSI CAL THERAPY		0. 55885			
9. 00 06900 ELECTROCARDI OLOGY		0. 10108		222	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 04594		10, 802	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 67389		0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 41350		28, 217	
4. 00 07400 RENAL DIALYSIS		0. 98837		0	1
OUTPATIENT SERVICE COST CENTERS	,				1
8. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88.
8.01 08801 RURAL HEALTH CLINIC II		0.00000	00	0	88.
3.02 08802 RURAL HEALTH CLINIC III		0.00000	00	0	88.
3.03 08803 RURAL HEALTH CLINIC IV		0.00000	00	0	88.
B. 04 08804 RURAL HEALTH CLINIC V		0.00000	00	0	88.
B. 05 08805 RURAL HEALTH CLINIC VI		0.00000		0	88.
D. 00 09000 CLI NI C		0. 92522	29 0	0	90.
D. 01 04951 CHEMO/PAI N		1. 20250	02 0	0	90.
D. 02 09002 SENI OR CARE		1. 86064		0	1
D. 03 09003 SLEEP LAB		0.00000		0	
0. 04 09001 0RTH0PEDI CS		1. 52288		0	
0.05 09004 BEHAVI ORAL HEALTH CLINIC		275. 85669		0	90.
1. 00 09100 EMERGENCY		0. 78902		0	
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		2. 77401	11 0	0	92.
OTHER REIMBURSABLE COST CENTERS					95.
5.00 09500 AMBULANCE SERVICES 6.00 09600 DURABLE MEDICAL EQUIP RENTED		3. 66070	04 0	0	

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

254, 550

254, 550

201. 00

202. 00

127, 540 200. 00

200.00

201.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/23/2024 4:0	pared:
	Ti ti	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS			12, 112		30.0
50.00 05000 OPERATING ROOM		0. 12354		0	50.0
53. 00 05300 ANESTHESI OLOGY		0. 27802		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17482		1, 146	54.0
50. 00 06000 LABORATORY		0. 18900		971	
55. 00 06500 RESPI RATORY THERAPY		1. 19789		7, 650	
66. 00 06600 PHYSI CAL THERAPY		0. 55885		0	
59. 00 06900 ELECTROCARDI OLOGY		0. 10108	, , , , , , , , , , , , , , , , , , , ,	201	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 04594		3, 423	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 67389		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 41350		2, 241	
74. 00 O7400 RENAL DI ALYSI S		0. 98837	79 0	0	74.0
OUTPATIENT SERVICE COST CENTERS		1 4/004	7 0		
88. 00 08800 RURAL HEALTH CLINIC		1. 46331		0	
8. 01 08801 RURAL HEALTH CLINIC II 8. 02 08802 RURAL HEALTH CLINIC III		1. 01082		0	88.0
88.03 08803 RURAL HEALTH CLINIC IV		2. 42513 0. 80813		0	88.0
8. 04 08804 RURAL HEALTH CLINIC V		0. 60877		0	88.0
18. 05 08805 RURAL HEALTH CLINIC VI		0.00000		0	88.0
0. 00 09000 CLINIC CLINIC VI		0. 00000		0	90.0
0. 00 09000 CET NT C 0. 01 04951 CHEMO/PAI N		1. 20250		0	90.0
10. 01 04931 CHEMO/PATN 10. 02 09002 SENI OR CARE		1. 86064		0	90.0
0. 02 09002 SENTOR CARE 0. 03 09003 SLEEP LAB		0. 00000		0	90.0
0. 03 09003 SLEEP LAB 0. 04 09001 0RTH0PEDI CS		1. 52288		0	90.0
0.05 09001 OKTHOPEDICS		275. 85669		0	90.0
1.00 09100 EMERGENCY		0. 78902		0	91. 0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 77401		0	1
OTHER REI MBURSABLE COST CENTERS		2.,,,	., .		1 /2.
95. 00 09500 AMBULANCE SERVICES					95.0
26. 00 09600 DURABLE MEDICAL FOULP RENTED		3, 66070	04	0	

3.660704

28, 763

28, 763

96. 00 0

202. 00

15, 632 200. 00 201. 00

96.00 09600 DURABLE MEDICAL EQUIP. - RENTED

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

		T: +1 - W/// I	11: 4-1	5/23/2024 4: 0	1 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			20, 433, 776	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		0	2.00
3.00	OPPS or REH payments Outlier payment (see instructions)			0	3. 00 4. 00
4. 00 4. 01	Outlier reconciliation amount (see instructions)	0	4. 00		
5. 00	Enter the hospital specific payment to cost ratio (see instruc	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 including REH direc	t graduate medical educa	ation costs from	0	9. 00
10.00	Wkst. D, Pt. IV, col. 13, line 200			0	10 00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 20, 433, 776	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			20, 433, 770	11.00
	Reasonable charges				İ
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
45.00	Customary charges				
15. 00 16. 00	Aggregate amount actually collected from patients liable for p	3	9	0	15. 00 16. 00
10.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		i a ciiai yebasi s	U	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lin	ne 11) (see	0	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			20, 638, 114	21. 00
22. 00	Interns and residents (see instructions)			20, 038, 114	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions			100, 720	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line			8, 732, 889	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23] (see	11, 804, 505	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)	116 30)		O	28. 50
29. 00	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)			11, 804, 505	•
31. 00	Primary payer payments			1, 701	
32. 00	Subtotal (line 30 minus line 31)			11, 802, 804	32. 00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			00.00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 285, 477	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			185, 560	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		148, 945	
37. 00	Subtotal (see instructions)	,		11, 988, 364	1
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		-	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac	ed devices (see instruc-	tions)	0	39. 97 39. 98
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	devices (see ilistiuc	1 0113)	0	39. 90
40. 00	Subtotal (see instructions)			11, 988, 364	40.00
40. 01	Sequestration adjustment (see instructions)			239, 767	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41. 00	Interim payments			10, 602, 193	
41. 01	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			U	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			1, 146, 404	1
43. 01	Balance due provider/program-PARHM (see instructions)			., , 104	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2, o	chapter 1,	99, 917	44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00
	Time Value of Money (see instructions)				93.00
			<u> </u>		

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1320	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/23/2024 4:0) i pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				C	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				C	200. 00

Health Financial Systems PAR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1320

					5/23/2024 4: 01	1 pm
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider	1.00	3, 994, 475	3.00	10, 304, 251	1. 00
2.00	Interim payments payable on individual bills, either		3, 774, 473		10, 304, 231	2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/15/2023	18, 204		79, 774	3. 01
3.02		08/24/2023	72, 016	08/24/2023	218, 168	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program	1		1		
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54	Cultural (0 220		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		90, 220		297, 942	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 084, 695		10, 602, 193	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		4, 004, 073		10, 002, 173	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			L		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program	1	_	T	_	
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Subtatal (sum of lines E O1 E 40 minus sum of lines		0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		444, 076		1, 146, 404	6. 01
6. 02	SETTLEMENT TO PROGRAM		1444,070		1, 140, 404	6. 02
7.00	Total Medicare program liability (see instructions)		4, 528, 771		11, 748, 597	7. 00
7.50	1.22a. man dar o program readerity (300 motivations)		.,020,771	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1, 00	2. 00	
					2.00	

					5/23/2024 4: 0	1 pm
				wing Beds - SNF		
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		582, 734		0	1. 00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	10/15/0000	1			
3. 01	ADJUSTMENTS TO PROVIDER	12/15/2023	14, 680		0	3. 01
3. 02		08/24/2023	31, 241		0	3. 02
3. 03			C		0	3. 03
3. 04			C		0	3. 04
3. 05			c)	0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM		1 0	,	0	2 50
3. 50 3. 51	ADJUSIMENTS TO PROGRAM					3. 50 3. 51
3.51				1		3. 51
3. 52						3. 52
3. 53						3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		45, 921			3. 99
3. 99	3. 50-3. 98)		45, 921		U	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		628, 655		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		020, 030			7.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		I.			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		[c		0	5. 01
5.02			[c		0	5. 02
5.03			C)	0	5. 03
	Provider to Program		1			
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		102, 669		0	6. 01
6. 01	SETTLEMENT TO PROVIDER		102, 669		0	6.01
6. 02 7. 00			731, 324			
7.00	Total Medicare program liability (see instructions)		131,324	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	1	1		1	' '	

Heal th	Financial Systems PARIS COMMU	JNITY HOSPITAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1320 Period: W					
	From 01/01/2023 To 12/31/2023					
				5/23/2024 4:0		
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA	ATI ON				
1.00	Total hospital discharges as defined in AARA §4102 from \	Wkst. S-3, Pt. I col. 15 line	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 20	00			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 instruction	ns)			8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10. 00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions))			30. 00	
31.00	Other Adjustment (specify)				31.00	
22 00	20 Palance due provider (line 0 (en line 10) minus line 20 and line 21) (ess instructions)					

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

30. 00 31. 00 32. 00

		Component CCN: 14-Z320	To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
		Title XVIII	Swing Beds - SNF		. p
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPTED CERTIFICATION		1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		(10, 224	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)	619, 234	0	1. 00 2. 00	
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	128, 815	0		
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir				3.00
	instructions)	g zea pass till eagil, 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 teachi	ng program (see		0.00	4. 00
	instructions)				
5.00	Program days		206	0	•
6.00	Interns and residents not in approved teaching program (see in	istructions)		0	
7.00	Utilization review - physician compensation - SNF optional met	nod only	740.040		7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		748, 049	0	
10. 00	Subtotal (line 8 minus line 9)		748, 049	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	740, 049	0	
11.00	professional services)	able to physician			11.00
12. 00	Subtotal (line 10 minus line 11)		748, 049	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	1, 800	0	
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (see instructions)		746, 249	0	1
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	•	_		16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	Ö	
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	Ö	
19. 00	Total (see instructions)	,	746, 249	0	
19. 01	Sequestration adjustment (see instructions)		14, 925	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	
20. 00	Interim payments		628, 655	0	
20. 01	Interim payments-PARHM		_	_	20. 01
21.00	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)	10 2F 20 and 21)	100 ((0	0	21. 01
22. 00 22. 01	Balance due provider/program (line 19 minus lines 19.01, 19.02 Balance due provider/program-PARHM (see instructions)	., 19.25, 20, and 21)	102, 669	U	22. 00 22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	uce with CMS Dub 15_2	0	0	1
23.00	chapter 1, §115.2	ice with clas rub. 13-2,	0		25.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment			1
200.00	Is this the first year of the current 5-year demonstration per				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 W	/kst. D-1, Pt. II, line			201. 00
000 00	66 (title XVIII hospital))	W . D			000 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	I WKST. D-3, COL. 3, III	е		202. 00
203 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
201.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demonst	tration	201.00
	peri od)		,		
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	ement			
207.00	Program reimbursement under the §410A Demonstration (see instr	uctions)			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	, col. 1, sum of lines	1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	trons)			209. 00
∠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 2	200 plus line 210) (222			215. 00
Z 10. UC	instructions)	.o, prus rine 210) (See			210.00
			1	1	•

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of	Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1320	From 01/01/2023 Part To 12/31/2023 Date	
·	Title XVIII	Hospi tal	Cost

				5/23/2024 4:0	1 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpatient services			5, 065, 784	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3.00	Organ acquisition	0.10)		0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			5, 065, 784	
5. 00	Primary payer payments			5, 251	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 111, 191	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			5, 111, 171	0.00
	Reasonable charges				
7 00				0	7. 00
7.00	Routine service charges			- 1	
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	10. 00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for			-	11. 00
12. 00	Amounts that would have been realized from patients liable fo	1 3	n a charge basis	0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e)			
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14. 00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds lin	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds line	e 14) (see	0	16. 00
	instructions)			0	17. 00
17. 00					
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			5, 111, 191	
20.00	Deductibles (exclude professional component)			499, 495	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			4, 611, 696	22. 00
23.00	Coinsurance			800	23.00
24.00	Subtotal (line 22 minus line 23)			4, 610, 896	24.00
25.00	Allowable bad debts (exclude bad debts for professional servi-	ces) (see instructions)		15, 844	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			10, 299	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 536	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4, 621, 195	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
29. 98	Recovery of accelerated depreciation.	-,		0	
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			4, 621, 195	
30. 01	Sequestration adjustment (see instructions)			92, 424	
30. 02	Demonstration payment adjustment amount after sequestration			72, 121	30. 02
30. 03	Sequestration adjustment-PARHM			O	30. 02
31. 00				4, 084, 695	
31. 00					31. 00
32. 00	Tentative settlement (for contractor use only)	0	-		
32. 00	Tentative settlement (for contractor use only)			U	32. 00
32.01	Balance due provider/program (line 30 minus lines 30.01, 30.0	2 21 and 22)		444 074	
			and 22 01)	444, 076	33. 00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		,	E E4E	
34. 00	Protested amounts (nonallowable cost report items) in accorda	nce with two Pub. 15-2, (chapter I,	5, 545	34. 00
	§115. 2				

Health Financial Systems PARIS COMM
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 14-1320

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

onl y)			'	0 12/31/2023	5/23/2024 4:0	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS				_	
1.00	Cash on hand in banks	1, 619, 371	C	0	0	1.00
2. 00 3. 00	Temporary i nvestments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts receivable	43, 522, 958	1	0	0	4. 00
5. 00	Other recei vabl e	4, 201, 168		0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-28, 286, 019	l .	0	0	6. 00
7.00	Inventory	3, 285, 093	C	0	0	7. 00
8.00	Prepaid expenses	970, 534	C	0	0	
9.00	Other current assets	0	O C	0	0	
10.00	Due from other funds	0	C		0	1
11. 00	Total current assets (sum of lines 1-10)	25, 313, 105	<u> </u>	0	0	11. 00
12. 00	FI XED ASSETS Land	1, 626, 832		0	0	12. 00
13. 00	Land improvements	4, 293, 681		-	0	13. 00
14. 00	Accumulated depreciation	-2, 505, 524	-		0	14. 00
15. 00	Bui I di ngs	73, 200, 538	1	0	0	15. 00
16. 00	Accumulated depreciation	-27, 136, 731	C	0	0	16. 00
17. 00	Leasehold improvements	7, 632, 592	1	0	0	17. 00
18.00	Accumulated depreciation	-233, 511	0		0	18.00
19.00	Fi xed equipment	0	C	-	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0	O C	0	0	20.00
22. 00	Accumulated depreciation	0		0	0	22.00
23. 00	Major movable equipment	29, 111, 249		0	0	23. 00
24. 00	Accumulated depreciation	-21, 929, 938	l .	0	0	24. 00
25. 00	Mi nor equi pment depreci able	0	C	0	0	25. 00
26. 00	Accumulated depreciation	0	C	0	0	26. 00
27. 00	HIT designated Assets	0	O C	0	0	27. 00
28. 00	Accumulated depreciation	0	C	0	0	28. 00
29. 00	Minor equipment-nondepreciable	(4.050.100		_	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	64, 059, 188	<u> </u>	l O	U	30.00
31. 00	Investments	0	C	0	0	31. 00
32.00	Deposits on Leases	0	o c	0	0	32. 00
33.00	Due from owners/officers	0	C	0	0	33. 00
34.00	Other assets	0	C	-	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	0	C		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	89, 372, 293	C	0	0	36.00
37. 00	Accounts payable	7, 370, 534	l c	0	0	37. 00
38. 00	Salaries, wages, and fees payable	152, 017	1	0	Ö	38.00
39. 00	Payroll taxes payable	5, 790, 171	1	0	0	39. 00
40.00	Notes and Loans payable (short term)	22, 366, 108	c c	0	0	40. 00
41. 00	Deferred income	0	C	0	0	41. 00
42. 00	Accel erated payments	0	_	_	_	42. 00
43.00	Due to other funds	0 727 0/0		0	0	1
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	2, 727, 068 38, 405, 898			0	
43.00	LONG TERM LIABILITIES	30, 403, 070		0	0	43.00
46. 00	Mortgage payable	0	C	0	0	46. 00
47.00	Notes payable	0	o c	0	0	47. 00
48. 00	Unsecured Loans	0	C	0	0	
49. 00	Other long term liabilities	0	C		0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0 405 000	C		0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	38, 405, 898	<u> </u> C	0	0	51.00
52. 00	General fund balance	50, 966, 395				52.00
53. 00	Specific purpose fund	00,700,070				53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	50, 966, 395	d	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	89, 372, 293	i	l ol	0	
	59)	,				
	·		•	. '		

Provider CCN: 14-1320

					То	12/31/2023	Date/Time Pre 5/23/2024 4:0	
		General	Fund	Speci al	Purpo	se Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		52, 177, 991			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1, 211, 596			0		2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		50, 966, 395		0	Ü	0	3. 00 4. 00
5.00	Additions (credit adjustments) (specify)				0		0	5. 00
6.00					0		l ő	6. 00
7. 00		0			0		0	7. 00
8.00		0			0		0	8.00
9.00		0			0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		50, 966, 395			0		11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0		0	12. 00 13. 00
14. 00					0		0	14. 00
15. 00					0		0	15. 00
16. 00					o		Ö	16. 00
17. 00		0			0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		50, 966, 395			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Eridowiiicht Fand	Traire	Tana				
		6.00	7. 00	8. 00			,	
1.00	Fund balances at beginning of period	0			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4.00	Additions (credit adjustments) (specify)		0		O			4. 00
5. 00	That trons (or car trady as therets) (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 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0			10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)		0		U			12. 00
13. 00	beddetrons (debrt adjustments) (speerry)		0					13. 00
14. 00			0					14. 00
15.00			0					15.00
16. 00			0					16. 00
17. 00	T + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 +		0					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0			18. 00 19. 00
19.00	sheet (line 11 minus line 18)				U			19.00
	1 (1		ļ.	Ţ			

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1320

		1	o 12/31/2023	Date/Time Pre 5/23/2024 4:0	
	Cost Center Description	Inpatient	Outpati ent	Total	Гріп
	<u> </u>	1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	8, 396, 264		8, 396, 264	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	(0	5. 00
6.00	Swing bed - NF)	0	6. 00
7. 00 8. 00	SKILLED NURSING FACILITY NURSING FACILITY				7. 00 8. 00
9. 00	OTHER LONG TERM CARE	+			9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	8, 396, 264		8, 396, 264	10.00
10.00	Intensive Care Type Inpatient Hospital Services	0, 370, 202		0, 370, 204	10.00
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of line	es (0	16. 00
	11-15)			Ü	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 396, 264		8, 396, 264	17. 00
18.00	Ancillary services	2, 830, 733	191, 788, 477	194, 619, 210	18. 00
19.00	Outpati ent servi ces	319, 694	30, 870, 452	31, 190, 146	19. 00
20.00	RURAL HEALTH CLINIC	(11, 488, 975	20. 00
20. 01	RURAL HEALTH CLINIC II	(857, 901	857, 901	20. 01
20. 02	RURAL HEALTH CLINIC III	(365, 688	365, 688	20. 02
20. 03	RURAL HEALTH CLINIC IV		5, 285, 721	5, 285, 721	20. 03
20. 04	RURAL HEALTH CLINIC V			1, 403, 565	20. 04
20. 05	RURAL HEALTH CLINIC VI		o	0	20. 05
21.00	FEDERALLY QUALIFIED HEALTH CENTER		o	0	21. 00
22.00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES		0	0	23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to N	Wkst. 11,546,691	242, 060, 779	253, 607, 470	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		127, 035, 272		29. 00
30.00	ADD (SPECIFY)				30. 00
31. 00					31. 00
32. 00		(1		32. 00
33. 00		(1		33. 00
34. 00		(34.00
35. 00		(35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00			1		38. 00
39. 00		(39. 00
40. 00		(40.00
41. 00	T + 1 + 1 + 1		<u> </u>		41.00
42.00	Total deductions (sum of lines 37-41)		107 005 070		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(to	ranster	127, 035, 272		43. 00
	to Wkst. G-3, line 4)	T.	1		l

	Financial Systems	PARIS COMMUNITY H			u of Form CMS-	
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 14-1320	Peri od: From 01/01/2023	Worksheet G-3	
				To 12/31/2023	Date/Time Pre	pared:
				1	5/23/2024 4:0	
					1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Par				253, 607, 470	
2.00	Less contractual allowances and discounts of	on patients' accounts	S		135, 955, 949	
3.00	Net patient revenues (line 1 minus line 2)				117, 651, 521	
4. 00	Less total operating expenses (from Wkst. 0		3)		127, 035, 272	
5. 00	Net income from service to patients (line 3	3 minus line 4)			-9, 383, 751	5.00
	OTHER I NCOME			1	4 404 070	
6.00	Contributions, donations, bequests, etc				1, 424, 079	
7. 00	Income from investments				61, 783	
8. 00					0	
9. 00	Revenue from television and radio service				0	
10. 00	Purchase di scounts				16, 498	
11. 00	Rebates and refunds of expenses				16, 160	
12. 00	Parking Lot receipts				0	
	Revenue from Laundry and Linen service				0	
	Revenue from meals sold to employees and gu	uests			194, 469	
15. 00	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical s		an patients		15, 184	
	Revenue from sale of drugs to other than pa				0	
18. 00	Revenue from sale of medical records and ab				6, 888	
	Tuition (fees, sale of textbooks, uniforms,	,			0	
20. 00	Revenue from gifts, flowers, coffee shops,	and canteen			0	
	Rental of vending machines				0	
22. 00	Rental of hospital space				111, 300	
23. 00	Governmental appropriations				0	
24. 00	OTHER OPERATING INCOME				6, 325, 794	
	COVI D-19 PHE Fundi ng				0	
	Total other income (sum of lines 6-24)				8, 172, 155	
	Total (line 5 plus line 25)				-1, 211, 596	
	OTHER EXPENSES (SPECIFY)				0	
	Total other expenses (sum of line 27 and su				0	
29. 00	Net income (or loss) for the period (line 2	26 minus line 28)			-1, 211, 596	29.00

Total Costs Basis Statistics Fits per 2080 Hours						5/23/2024 4: 0	l pm
1.00 2.00 3.00 4.00					Renal Dialysis		
1.00			Total Costs	Basi s	Statistics	FTEs per 2080	
1.00						Hours	
2. 00			1.00	2. 00	3. 00	4. 00	
3.00 NURSES AIDES O HOURS OF SERVICE 0.00 0.00 3.00		REGI STERED NURSES	123, 783 H	HOURS OF SERVICE	3, 076. 00		
4. 00 TECHNICIANS 91, 751 HOURS OF SERVICE 3, 394. 00 1. 63 4. 00	2.00	LI CENSED PRACTI CAL NURSES	0	HOURS OF SERVICE	0.00	0.00	2.00
5. 00 SOCI AL WORKERS 75, 045 HOURS OF SERVICE 1, 953.00 0.94 5. 00	3.00	NURSES AI DES	0	HOURS OF SERVICE	0.00	0.00	3.00
6. 00 DI ETI CI ANS 7. 00 PHYSI CI ANS 7. 00 PHYSI CI ANS 8. 00 NON-PATI ENT CARE SALARY 9. 00 SUBTOTAL (SUM OF LI NES 1-8) 10. 00 EMPLOYEE BENEFI TS 11. 00 CAPI TAL RELATED COSTS-BLDGS. & FI XTURES 12. 00 CAPI TAL RELATED COSTS-MOV. EQUI P. 13. 00 MACHINE COSTS & REPAIRS 10. 00 CAPI TAL RELATED COSTS-MOV. EQUI P. 14. 01 PEDI ATRIC MEDI CAL SUPPLIES 15. 00 DREQUI SI TI ONS 16. 00 OTHER 17. 00 SUBTOTAL (SUM OF LI NES 9-16)* 18. 00 OREQUI SI TI ONS 19. 00 CAPI TAL RELATED COSTS-BLDGS. & FI XTURES 19. 00 CAPI TAL RELATED COS			91, 751	HOURS OF SERVICE	3, 394. 00		
7. 00 Physicians	5.00	SOCI AL WORKERS	75, 045 H	HOURS OF SERVICE	1, 953. 00	0. 94	5.00
8. 00 NON-PATIENT CARE SALARY 214, 546 ACCUMULATED COST 9. 00 SUBTOTAL (SUM OF LI NES 1-8) 544, 300 9. 00 10. 00 EMPLOYEE BENEFITS 68, 268 SALARY 10. 00 11. 00 CAPITAL RELATED COSTS-BLDGS. & FIXTURES 1, 245 SOUARE FEET 11. 00	6.00	DI ETI CI ANS	39, 175 H	HOURS OF SERVICE	1, 002. 00	0. 48	6.00
9.00 SUBTOTAL (SUM OF LINES 1-8) 544, 300 68, 268 SALARY 10.00 CAPI TAL RELATED COSTS-BLDGS. & FIXTURES 1, 245 SQUARE FEET 11.00 CAPI TAL RELATED COSTS-MOV. EQUI P. 21, 623 PERCENTAGE OF TI ME 12.00 13.00 MACHI NE COSTS & REPAI RS 0 PERCENTAGE OF TI ME 13.00 MACHI NE COSTS & REPAI RS 0 PERCUI SI TI ONS 14.00 14.00 PEDI ATTRIC MEDI CAL SUPPLI ES 0 REQUI SI TI ONS 15.00 DRUGS 0 PECUI SI TI ONS 15.00 DRUGS 0 PECUI SI TI ONS 15.00 DRUGS 0 PECUI SI TI ONS 15.00 OREQUI SI TI ONS 15.0	7.00	PHYSI CI ANS	0/4	ACCUMULATED COST			7. 00
10. 00 EMPLOYEE BENEFITS		NON-PATIENT CARE SALARY	214, 546	ACCUMULATED COST			8. 00
11. 00	9.00	SUBTOTAL (SUM OF LINES 1-8)	544, 300				9. 00
12. 00 CAPITAL RELATED COSTS-MOV. EQUIP. 13. 00 MACHINE COSTS & REPAIRS 0 PERCENTAGE OF TIME 13. 00 14. 01 PEDI ATRIC MEDICAL SUPPLIES 0 OREQUISITIONS 14. 01 15. 00 DRUGS 16. 00 OTHER 17. 00 SUBTOTAL (SUM OF LINES 9-16)* 18. 00 CAPITAL RELATED COSTS-BLDGS. & FIXTURES 19. 00 DEMPLOYEE BENEFITS DEPARTMENT 10. 00 ADMINISTRATIVE & GENERAL 10. 00 CAPITAL RELATED COSTS 10. 00 MEDICAL EDUCATION PROGRAM COSTS 10. 00 CENTRAL SERVICE & SUPPLIES 10. 00 CENTRAL SERVICE & SUPPLIES 10. 00 OTHER ALLOCATED COSTS 10. 00 OTHER ALLOCATED COSTS 10. 00 OTHER ALLOCATED COSTS 10. 01 CHARGES 10. 02. 00 10. 02. 00 OTHER ANCILLARY SERVICE COST CENTERS 10. 01 CHARGES 10. 02. 00 10. 00 OTHER ANCILLARY SERVICE COST CENTERS 10. 00 CHARGES 10. 00 OTHER ANCILLARY SERVICE COST CENTERS 11. 3. 15, 585 12. 00 13. 00 14. 00 15. 00	10.00	EMPLOYEE BENEFITS	68, 268	SALARY			10.00
13. 00	11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	1, 245	SQUARE FEET			11.00
14. 00 SUPPLIES OREQUISITIONS 14. 00 14. 01 PEDIATRIC MEDICAL SUPPLIES OREQUISITIONS 14. 01 15. 00 DRUGS OREQUISITIONS 0REQUISITIONS 15. 00 16. 00 OTHER 306, 030 ACCUMULATED COST 16. 00 17. 00 SUBTOTAL (SUM OF LINES 9-16)* 941, 466 17. 00 18. 00 CAPITAL RELATED COSTS-BLDGS. & FIXTURES OSQUARE FEET 18. 00 19. 00 CAPITAL RELATED COSTS-MOV. EQUIP. OPERCENTAGE OF TIME 19. 00 20. 00 EMPLOYEE BENEFITS DEPARTMENT 154, 015 SALARY 20. 00 21. 00 ADMINISTRATIVE & GENERAL 153, 213 ACCUMULATED COST 21. 00 22. 00 MAINT. / REPAIRS-OPER-HOUSEKEEPING OSQUARE FEET 22. 00 23. 00 MEDICAL EDUCATION PROGRAM COSTS OREQUISITIONS 23. 00 24. 00 CENTRAL SERVICE & SUPPLIES OREQUISITIONS 25. 00 25. 00 PHARMACY OREQUISITIONS 25. 00 26. 00 OTHER ALLOCATED COSTS 1, 315, 585 27. 00 28. 00 LABORATORY (SEE INSTRUCTIONS) OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES OCHARGES OCHARGES OCHARGES OCHARGES OCHAR	12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	21, 623 F	PERCENTAGE OF TIME			12.00
14. 01 PEDIATRIC MEDICAL SUPPLIES OREQUISITIONS 15. 00 15. 00 DRUGS OREQUISITIONS 15. 00 16. 00 OTHER 306, 030 17. 00 SUBTOTAL (SUM OF LINES 9-16)* 16. 00 18. 00 CAPITAL RELATED COSTS-BLDGS. & FIXTURES 0 19. 00 CAPITAL RELATED COSTS-MOV. EQUIP. 0 19. 00 CAPITAL RELATED COSTS-MOV. EQUIP. 0 19. 00 EMPLOYEE BENEFITS DEPARTMENT 154, 015 SALARY 20. 00 21. 00 ADMINISTRATIVE & GENERAL 153, 213 ACCUMULATED COST 21. 00 22. 00 MAINT. / REPAIRS-OPER-HOUSEKEEPING 0 23. 00 MEDICAL EDUCATION PROGRAM COSTS 0 24. 00 CENTRAL SERVICE & SUPPLIES 0 REQUISITIONS 24. 00 25. 00 PHARMACY 0 REQUISITIONS 25. 00 26. 00 OTHER ALLOCATED COSTS 1, 315, 585 27. 00 28. 00 LABORATORY (SEE INSTRUCTIONS) 0 CHARGES 0 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 CHARGES 0 30. 00 14. 01 OREQUISITIONS 15. 00 306, 030 ACCUMULATED COST 15. 00 306, 030 OREQUISITIONS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0	13.00	MACHINE COSTS & REPAIRS	OF	PERCENTAGE OF TIME			13.00
15. 00 DRUGS 0 DRUGS 15. 00 16. 00 16. 00 17. 00 17. 00 SUBTOTAL (SUM OF LINES 9-16)* 941, 466 17. 00 18. 00 CAPITAL RELATED COSTS-BLDGS. & FIXTURES 0 SQUARE FEET 18. 00 19. 00 CAPITAL RELATED COSTS-MOV. EQUIP. 0 PERCENTAGE OF TIME 19. 00 0 PERCENTAGE OF TIME 19. 00 0 PERCENTAGE OF TIME 19. 00 0 0 0 0 0 0 0 0 0	14.00	SUPPLIES	OF	REQUI SI TI ONS			14.00
16. 00 OTHER 17. 00 SUBTOTAL (SUM OF LINES 9-16)* 18. 00 CAPITAL RELATED COSTS-BLDGS. & FIXTURES 19. 00 CAPITAL RELATED COSTS-MOV. EQUIP. 20. 00 EMPLOYEE BENEFITS DEPARTMENT 21. 00 ADMINISTRATIVE & GENERAL 22. 00 MAINT. /REPAIRS-OPER-HOUSEKEEPING 23. 00 MEDICAL EDUCATION PROGRAM COSTS 24. 00 CENTRAL SERVICE & SUPPLIES 0 REQUISITIONS 0 OTHER ALLOCATED COSTS 0 OTHER ALLOCATED COSTS 26. 00 OTHER ALLOCATED COSTS 27. 00 SUBTOTAL (SUM OF LINES 17-26)* 28. 00 LABORATORY (SEE INSTRUCTIONS) 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 SQUARE FEET	14. 01	PEDIATRIC MEDICAL SUPPLIES	OF	REQUI SI TI ONS			14. 01
17. 00 SUBTOTAL (SUM OF LINES 9-16)* 18. 00 CAPITAL RELATED COSTS-BLDGS. & FIXTURES 19. 00 CAPITAL RELATED COSTS-MOV. EQUI P. 20. 00 EMPLOYEE BENEFITS DEPARTMENT 21. 00 ADMINISTRATIVE & GENERAL 22. 00 MAINT. / REPAIRS - OPER - HOUSEKEEPING 23. 00 MEDICAL EDUCATION PROGRAM COSTS 24. 00 CENTRAL SERVICE & SUPPLIES 0 REQUISITIONS 25. 00 PHARMACY 0 CENTRAL SERVICE & SUPPLIES 0 REQUISITIONS 26. 00 OTHER ALLOCATED COSTS 27. 00 SUBTOTAL (SUM OF LINES 17-26)* 28. 00 LABORATORY (SEE INSTRUCTIONS) 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 CHARGES 0 CHARGES 0 CHARGES 0 OTHER ANCILLARY SERVICE COST CENTERS	15.00	DRUGS	OF	REQUI SI TI ONS			15.00
18. 00 CAPITAL RÈLATED COSTS-BLOGS. & FIXTURES 19. 00 CAPITAL RELATED COSTS-MOV. EQUI P. 20. 00 EMPLOYEE BENEFITS DEPARTMENT 21. 00 ADMI NI STRATI VE & GENERAL 22. 00 MAINT. / REPAI RS-OPER-HOUSEKEEPI NG 23. 00 MEDI CAL EDUCATI ON PROGRAM COSTS 24. 00 CENTRAL SERVI CE & SUPPLI ES 0 REQUI SI TI ONS 25. 00 PHARMACY 0 OTHER ALLOCATED COSTS 26. 00 27. 00 SUBTOTAL (SUM OF LI NES 17-26)* 28. 00 LABORATORY (SEE I NSTRUCTI ONS) 29. 00 RESPI RATORY THERAPY (SEE I NSTRUCTI ONS) 30. 00 OTHER ANCI LLARY SERVI CE COST CENTERS 0 SQUARE FEET 18. 00 0 PERCENTAGE OF TI ME 19. 00 153, 213 ACCUMULATED COST 20. 00 153, 213 ACCUMULATED COST 21. 00 22. 00 23. 00 0 REQUI SI TI ONS 24. 00 0 REQUI SI TI ONS 25. 00 0 CHARGES 0 28. 00 29. 00 30. 00 OTHER ANCI LLARY SERVI CE COST CENTERS	16.00	OTHER	306, 030	ACCUMULATED COST			16.00
19. 00 CAPITAL RELATED COSTS-MOV. EQUIP. 20. 00 EMPLOYEE BENEFITS DEPARTMENT 21. 00 ADMINISTRATIVE & GENERAL 22. 00 MAINT. /REPAIRS-OPER-HOUSEKEEPING 23. 00 MEDICAL EDUCATION PROGRAM COSTS 24. 00 CENTRAL SERVICE & SUPPLIES 25. 00 PHARMACY 26. 00 OTHER ALLOCATED COSTS 27. 00 SUBTOTAL (SUM OF LINES 17-26)* 28. 00 LABORATORY (SEE INSTRUCTIONS) 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 PERCENTAGE OF TIME 19. 00 154, 015 SALARY 20. 00 153, 213 ACCUMULATED COST 21. 00 0 SQUARE FEET 22. 00 0 SQUARE FEET 22. 00 0 REQUISITIONS 23. 00 0 REQUISITIONS 24. 00 0 REQUISITIONS 25. 00 0 CHARGES 0 QCHARGES	17.00	SUBTOTAL (SUM OF LINES 9-16)*	941, 466				17.00
20. 00 EMPLOYEE BENEFITS DEPARTMENT 154, 015 SALARY 20. 00 21. 00 ADMI NI STRATI VE & GENERAL 153, 213 ACCUMULATED COST 21. 00 22. 00 MAI NT. / REPAI RS-OPER-HOUSEKEEPI NG 0 SQUARE FEET 22. 00 23. 00 MEDI CAL EDUCATI ON PROGRAM COSTS 0 23. 00 24. 00 CENTRAL SERVI CE & SUPPLI ES 0 REQUI SI TI ONS 24. 00 25. 00 PHARMACY 0 REQUI SI TI ONS 25. 00 26. 00 OTHER ALLOCATED COSTS 25. 00 27. 00 SUBTOTAL (SUM OF LI NES 17-26)* 1, 315, 585 27. 00 28. 00 LABORATORY (SEE I NSTRUCTI ONS) 0 CHARGES 0 28. 00 29. 00 RESPI RATORY THERAPY (SEE INSTRUCTI ONS) 0 CHARGES 0 29. 00 30. 00 OTHER ANCI LLARY SERVI CE COST CENTERS 0 CHARGES 0 30. 00	18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0 5	SQUARE FEET			18.00
21. 00 ADMI NI STRATI VE & GENERAL 153, 213 ACCUMULATED COST 21. 00 22. 00 MAI NT. / REPAI RS-OPER-HOUSEKEEPI NG 0 SQUARE FEET 22. 00 23. 00 MEDI CAL EDUCATI ON PROGRAM COSTS 0 23. 00 24. 00 CENTRAL SERVI CE & SUPPLI ES 0 REQUI SI TI ONS 24. 00 25. 00 PHARMACY 0 REQUI SI TI ONS 25. 00 26. 00 OTHER ALLOCATED COSTS 25. 00 27. 00 SUBTOTAL (SUM OF LI NES 17-26)* 1, 315, 585 27. 00 28. 00 LABORATORY (SEE INSTRUCTI ONS) 0 CHARGES 0 28. 00 29. 00 RESPI RATORY THERAPY (SEE INSTRUCTI ONS) 0 CHARGES 0 29. 00 30. 00 OTHER ANCI LLARY SERVI CE COST CENTERS 0 CHARGES 0 30. 00	19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	OF	PERCENTAGE OF TIME			19.00
22. 00 MAINT. / REPAIRS - OPER - HOUSEKEEPING 0 SQUARE FEET 22. 00 23. 00 MEDICAL EDUCATION PROGRAM COSTS 0 23. 00 24. 00 CENTRAL SERVICE & SUPPLIES 0 REQUISITIONS 24. 00 25. 00 PHARMACY 0 REQUISITIONS 25. 00 26. 00 OTHER ALLOCATED COSTS 25. 00 27. 00 SUBTOTAL (SUM OF LINES 17-26)* 27. 00 28. 00 LABORATORY (SEE INSTRUCTIONS) 0 CHARGES 0 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 0 CHARGES 0 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0	20.00	EMPLOYEE BENEFITS DEPARTMENT	154, 015	SALARY			20.00
23. 00 MEDI CAL EDUCATI ON PROGRAM COSTS 0 CENTRAL SERVI CE & SUPPLI ES 0 OREQUI SI TI ONS 24. 00 25. 00 PHARMACY OREQUI SI TI ONS 25. 00 26. 00 OTHER ALLOCATED COSTS 26. 00 27. 00 SUBTOTAL (SUM OF LI NES 17-26)* 1, 315, 585 27. 00 28. 00 LABORATORY (SEE I NSTRUCTI ONS) 0 CHARGES 0 28. 00 29. 00 RESPI RATORY THERAPY (SEE I NSTRUCTI ONS) 0 CHARGES 0 29. 00 30. 00 OTHER ANCI LLARY SERVI CE COST CENTERS 0 CHARGES 0 30. 00	21.00	ADMINISTRATIVE & GENERAL	153, 213	ACCUMULATED COST			21.00
24. 00 CENTRAL SERVI CE & SUPPLI ES 0 REQUI SI TI ONS 24. 00 25. 00 PHARMACY 0 REQUI SI TI ONS 25. 00 26. 00 OTHER ALLOCATED COSTS 66, 891 ACCUMULATED COST 26. 00 27. 00 SUBTOTAL (SUM OF LI NES 17-26)* 1, 315, 585 27. 00 28. 00 LABORATORY (SEE I NSTRUCTI ONS) 0 CHARGES 0 28. 00 29. 00 RESPI RATORY THERAPY (SEE I NSTRUCTI ONS) 0 CHARGES 0 29. 00 30. 00 OTHER ANCI LLARY SERVI CE COST CENTERS 0 CHARGES 0 30. 00	22.00	MAINT. / REPAIRS-OPER-HOUSEKEEPING	0 5	SQUARE FEET			22.00
25. 00 PHARMACY 0 REQUISITIONS 25. 00 26. 00 0THER ALLOCATED COSTS 26. 00 27. 00 SUBTOTAL (SUM OF LINES 17-26)* 1, 315, 585 27. 00 28. 00 LABORATORY (SEE INSTRUCTIONS) 0 CHARGES 0 28. 00 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 0 CHARGES 0 29. 00 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00	23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
26.00 OTHER ALLOCATED COSTS 66,891 ACCUMULATED COST 26.00 27.00 SUBTOTAL (SUM OF LINES 17-26)* 1,315,585 27.00 28.00 LABORATORY (SEE INSTRUCTIONS) 0 CHARGES 0 28.00 29.00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 0 CHARGES 0 29.00 30.00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30.00	24.00	CENTRAL SERVICE & SUPPLIES	OF	REQUI SI TI ONS			24.00
27. 00 SUBTOTAL (SUM OF LINES 17-26)* 1,315,585 27. 00 28. 00 LABORATORY (SEE INSTRUCTIONS) 0CHARGES 0 28. 00 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) 0CHARGES 0 29. 00 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0CHARGES 0 30. 00	25.00	PHARMACY	OF	REQUI SI TI ONS			25.00
28. 00 LABORATORY (SEE INSTRUCTIONS) OCHARGES 0 28. 00 29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) OCHARGES 0 29. 00 30. 00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30. 00	26.00	OTHER ALLOCATED COSTS	66, 891	ACCUMULATED COST			26.00
29. 00 RESPIRATORY THERAPY (SEE INSTRUCTIONS) OCHARGES 0 29. 00 30. 00 OTHER ANCILLARY SERVICE COST CENTERS 0 CHARGES 0 30. 00	27.00	SUBTOTAL (SUM OF LINES 17-26)*	1, 315, 585				27.00
30.00 OTHER ANCILLARY SERVICE COST CENTERS OCHARGES 0 30.00	28. 00		00	CHARGES	0		28. 00
	29. 00		0	CHARGES	0		29. 00
31.00 TOTAL COSTS (SUM OF LINES 27-30) 1,315,585 31.00	30.00			CHARGES	0		
	31.00	TOTAL COSTS (SUM OF LINES 27-30)	1, 315, 585				31.00

^{*} Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

	Financial Systems		PARIS COMMUNI				eu of Form CMS-2	
ALLOCA	ATION OF RENAL DEPARTMENT COSTS	TO TREATMENT MO	DALI TI ES	Provi der C		eriod: rom 01/01/2023	Worksheet I-2	
				Component		o 12/31/2023	Date/Time Pre	pared:
					1	Renal Dialysis	5/23/2024 4:0	т ріп
		Capital Rel	ated Costs	Direct Patien	nt Care Salary			
		Bui I di ng	Equi pment	RNs	Other	Employee	Drugs	
		barrarng	Equi pinerre	1113	o their	Benefits	Di ags	
		1.00	2.00	3. 00	4.00	Department	6. 00	
1.00	Total Renal Department Costs	1, 00	2. 00 21, 623	123, 783		5. 00 222, 283		1. 00
	MAI NTENANCE	·					-	
2. 00 2. 01	Hemodialysis	1, 245	21, 623	123, 783	205, 971	222, 283	0	2. 00 2. 01
2. 01	AKI-Hemodi al ysi s Hemodi al ysi s-Pedi atri c	0	0	0	0	0		1
3.00	Intermittent Peritoneal	0	O	0	0	0	0	3. 00
3. 01 3. 02	AKI-Intermittent Peritoneal IPD-Pediatric	0 0	0	0	0	0	0	
3.02	TRAI NI NG	<u> </u>	U _I	0	0	0	<u> </u>	3.02
4.00	Hemodi al ysi s	0	0	0	l .		1	
4. 01 5. 00	Hemodialysis-Pediatric Intermittent Peritoneal	0	0	0	0	0	0	4. 01 5. 00
5. 01	I PD-Pedi atri c	0	o	0	Ö	0	Ö	
6.00	CAPD	0	0	0	0	0	0	
6. 01 7. 00	CAPD-Pediatric	0	0	0	0	0	0	
7. 00 7. 01	CCPD-Pedi atri c	0	0	0		_		1
	HOME							
8. 00 8. 01	Hemodi al ysi s Hemodi al ysi s-Pedi atri c	0	0	0			0	
9. 00	Intermittent Peritoneal	0	o	0	Ö	0	ő	9. 00
9. 01	IPD-Pediatric	0	o	0	0	0	0	
10. 00 10. 01	CAPD CAPD-Pediatric	0	0	0	0	0	0	
11. 00	CCPD	0	o	0	0	0	0	1
11. 01	CCPD-Pedi atri c	0	o	0	0	0	0	11. 01
12. 00	OTHER BILLABLE SERVICES Inpatient Dialysis	O	ol	0	0	0	0	12. 00
13. 00	Method II Home Patient	0	o	0	Ö		Ö	13. 00
14. 00	ESAs (included in Renal						0	14. 00
15. 00	Department)							15. 00
16. 00	Other	o	0	0	o	0	0	1
17. 00	Total (sum of lines 2 through	1, 245	21, 623	123, 783	205, 971	222, 283	0	17. 00
18. 00	16) Medical Educational Program							18. 00
40.00	Costs							40.00
19. 00	Total Renal Costs (line 17 + line 18)							19. 00
		Medi cal	Pedi atri c	Routi ne	Subtotal (sum	0verhead	Total (col. 9	
		Suppl i es	Medi cal Suppl i es	Ancillary Services	of cols. 1-8)		+ col . 10)	
		7. 00	7. 01	8. 00	9. 00	10.00	11. 00	
1. 00	Total Renal Department Costs MAINTENANCE	0	0	0	574, 905	740, 680	1, 315, 585	1.00
2.00	Hemodi al ysi s	0	0	0	574, 905	740, 680	1, 315, 585	2. 00
2. 01	AKI - Hemodi al ysi s	0	0	0	0	0	0	
2. 02 3. 00	Hemodialysis-Pediatric Intermittent Peritoneal		0	0	0	0		
3. 01	AKI-Intermittent Peritoneal	Ō	ō	0	O	0	Ō	1
3. 02	I PD-Pedi atri c	0	0	0	0	0	0	3. 02
4. 00	TRAI NI NG Hemodi al ysi s	O	o	0	0	0	0	4. 00
4. 01	Hemodi al ysi s-Pedi atri c	Ō	ō	0			Ö	1
5.00	Intermittent Peritoneal	0	0	0	0	0	0	
5. 01 6. 00	I PD-Pedi atri c CAPD	0	0	0	0	0	0	
6. 01	CAPD-Pediatric	Ö	ō	0	0	0	0	1
7.00	CCPD	0	0	0		_	0	
7. 01	CCPD-Pedi atri c HOME	0	0	0	0	0	0	7. 01
8.00	Hemodi al ysi s	0	0	0	1		0	
8. 01 9. 00	Hemodialysis-Pediatric Intermittent Peritoneal	0	0	0	0	0	0	
9. 01	I PD-Pedi atri c	o	o	0	Ö	o	ő	1
10.00	CAPD	0	o	0	0	0	0	
10. 01 11. 00	CAPD-Pedi atri c	0 0	0	0	0	0	0	
	CCPD-Pedi atri c	o o	o	0		_		11. 01
		·	·					

Heal th	Financial Systems		PARIS COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF RENAL DEPARTMENT COSTS	TO TREATMENT N	MODALITIES	Provi der C	CN: 14-1320	Peri od:	Worksheet I-2	
				Component	CCN: 14-2341	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:0	pared: 1 pm
						Renal Dialysis		
		Medi cal	Pedi atri c	Routi ne	Subtotal (su	m Overhead	Total (col. 9	
		Suppl i es	Medi cal	Ancillary	of cols. 1-8	3)	+ col . 10)	
			Suppl i es	Servi ces				
		7. 00	7. 01	8. 00	9. 00	10. 00	11. 00	
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	(0	C)	0 0	0	12.00
13.00	Method II Home Patient	(ol ol	C		0 0	0	13.00
14. 00	ESAs (included in Renal Department)							14. 00
15.00								15. 00
16.00	Other	(ol ol	C		0 0	0	16. 00
17. 00	Total (sum of lines 2 through 16)	(0	C	574, 9	740, 680	1, 315, 585	17. 00
18. 00	Medical Educational Program Costs						0	18. 00
19. 00	Total Renal Costs (line 17 + line 18)						1, 315, 585	19. 00

Provider CCN: 14-1320 Peri od: From 01/01/2023 To 12/31/2023 BASIS Date/Time Prepared: 5/23/2024 4:01 pm Component CCN: 14-2341

Renal Dialysis						5/23/2024 4:0	т рііі	
			Capital Rel	ated Costs		t Care Salary		
			Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
1. 00	Total Renal Department Costs	0	1. 00 1, 245	2. 00 21, 623	3. 00 123, 783	4. 00 205, 971	5. 00 222, 283	1.00
	MAI NTENANCE							
2. 00 2. 01 2. 02 3. 00 3. 01 3. 02	Hemodi al ysi s AKI-Hemodi al ysi s Hemodi al ysi s-Pedi atri c Intermittent Peritoneal AKI-Intermittent Peritoneal IPD-Pedi atri c		100 0 0 0 0 0	100. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0. 00 0. 00 0. 00 0. 00	0. 00 0. 00 0. 00 0. 00	100 0 0 0 0	2. 00 2. 01 2. 02 3. 00 3. 01 3. 02
4. 00	TRAI NI NG Hemodi al ysi s		0	0.00	0.00	0.00	0	4.00
4. 01 5. 00 5. 01 6. 00 6. 01 7. 00 7. 01	Hemodi al ysi s-Pedi atri c Intermittent Peri toneal IPD-Pedi atri c CAPD CAPD-Pedi atri c CCPD CCPD-Pedi atri c		0 0 0 0 0 0	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0 0	4. 01 5. 00
8. 00	HOME Hemodi al ysi s		0	0.00	0.00	0.00	0	8. 00
8. 01 9. 00 9. 01 10. 00 10. 01 11. 00	Hemodialysis-Pediatric Intermittent Peritoneal IPD-Pediatric CAPD CAPD-Pediatric CCPD CCPD-Pediatric		0 0 0 0 0 0	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0 0	8. 01
12. 00	OTHER BILLABLE SERVICES Inpatient Dialysis Treatments	0	0	0.00	0.00	0.00	0	12. 00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Method II Home Patient ESAs Other Total Statistical Basis Unit Cost Multiplier (line 1 ÷		0 100 12. 450000	0. 00 0. 00 100. 00 216. 230000	0. 00 0. 00 100. 00	0. 00 0. 00 100. 00	0 0 100 2, 222. 830000	13. 00 14. 00 15. 00 16. 00 17. 00
	li ne 17)	Deugo	Medi cal	Pedi atri c	Routine	Subtotal	Overhead	10.00
		Drugs (Requist.)	Supplies (Requist.)	Medi cal Suppl i es (Requi st.)	Ancillary Services (Charges)		(Accum. Cost)	
1. 00	Total Renal Department Costs	6.00	7.00	7. 01 0	8.00	9. 00 574, 905	10. 00 740, 680	1. 00
	MAI NTENANCE						7 107 000	
2. 00 2. 01 2. 02 3. 00 3. 01 3. 02	Hemodi al ysi s AKI-Hemodi al ysi s Hemodi al ysi s-Pedi atri c Intermittent Peritoneal AKI-Intermittent Peritoneal IPD-Pedi atri c	0 0 0 0 0	0 0 0 0 0	0 0 0	0 0 0 0			2. 00 2. 01 2. 02 3. 00 3. 01 3. 02
4. 00	TRAI NI NG Hemodi al ysi s	0	0	0	0			4.00
4. 01 5. 00 5. 01 6. 00 6. 01 7. 00 7. 01	Hemodi al ysi s-Pedi atri c Intermittent Peri toneal IPD-Pedi atri c CAPD CAPD-Pedi atri c CCPD CCPD-Pedi atri c	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0	000000000000000000000000000000000000000			4. 01 5. 00 5. 01 6. 00 6. 01 7. 00 7. 01
8. 00	Hemodi al ysi s	0	0	0	0			8. 00
8. 01 9. 00 9. 01 10. 00 10. 01 11. 00	Hemodi al ysi s-Pedi atri c Intermittent Peri toneal IPD-Pedi atri c CAPD CAPD-Pedi atri c CCPD CCPD-Pedi atri c OTHER BILLABLE SERVICES	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	000000000000000000000000000000000000000			8. 01 9. 00 9. 01 10. 00 10. 01 11. 00
	Inpatient Dialysis Treatments Method II Home Patient	0	0					12. 00 13. 00
13.00	IMETHOU IT HOME PATIENT	1 0	1 0	<u> </u>	<u> </u>	<u> </u>		1 13.00

Health Financial Systems		PARIS COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
DIRECT AND INDIRECT RENAL DIALYSIS CO	OST ALLOCATION	- STATISTICAL	Provi der CC		Peri od:	Worksheet I-3	
BASIS					From 01/01/2023	D 1 /T' D	
			Component (CN: 14-2341	To 12/31/2023	Date/Time Prep 5/23/2024 4:0	
					Renal Dialysis		
	Drugs	Medi cal	Pedi atri c	Routi ne	Subtotal	0verhead	
	(Requist.)	Suppl i es	Medi cal	Ancillary		(Accum. Cost)	
		(Requist.)	Suppl i es	Servi ces			
			(Requist.)	(Charges)			
	6.00	7.00	7. 01	8. 00	9. 00	10.00	
14. 00 ESAs							14.00
15. 00							15.00
16.00 Other	0	0	0		0		16.00
17.00 Total Statistical Basis	0	0	0		0	574, 905	17.00
18.00 Unit Cost Multiplier (line 1 ÷	0. 000000	0. 000000	0. 000000	0.00000	0	1. 288352	18.00
line 17)							

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF AVERAGE COST PER	TREATMENT FOR OUTPATIENT RENAL	Provider CCN: 14-1320	Peri od:	Worksheet I-4
DI ALYSI S			From 01/01/2023	

Component CCN: 14-2341 To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm Rate 0 Renal Dialysis Average Cost Total Program Number of Total Cost Number of Total (from Wkst. Expenses (see of Treatments Program Treatments I-2, col. 11) Treatments instructions) $(col. 2 \div col$ 1) 1.00 2.00 3.00 4.00 5.00 Maintenance - Hemodialysis 758 1, 315, 585 1, 735. 60 758 1, 315, 585 1.00 1.00 Maintenance - AKI Hemodialysis Maintenance - Peritoneal Dialysis Maintenance - AKI Peritoneal Dialysis 1.01 0.00 1.01 00000000 0 0 0.00 0 2.00 C 0 2 00 2.01 0.00 0 2.01 Training - Hemodialysis 0 0.00 3.00 0 0 0 3.00 Training - Peritoneal Dialysis 4.00 0 0.00 0 4.00 Training - CAPD 5.00 0.00 0 5.00 6.00 Training - CCPD 0.00 0 0 6.00 Home Program - Hemodialysis Home Program - Peritoneal Dialysis 7.00 0.00 7.00 8.00 0.00 8.00 \cap Patient Weeks Patient Weeks 1.00 2.00 3.00 4. 00 5.00 Home Program - CAPD Home Program - CCPD 9.00 0.00 9. 00 0 0 0 0.00 10.00 10.00 0 0 Λ 11.00 Totals (sum of lines 1 through 8, cols. 1 758 1, 315, 585 758 1, 315, 585 11.00 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction) 12.00 12.00 Total treatments (sum of lines 1 through 8 758 plus (sum of lines 9 and 10 times 3)) (see instruction) Average Total Program Payment Rate Payment (col. 6 ÷ col. 4) 6.00 7.00 1.00 Maintenance - Hemodialysis 201, 712 266.11 1.00 Maintenance - AKI Hemodialysis 1.01 0 0.00 1.01 Maintenance - Peritoneal Dialysis Maintenance - AKI Peritoneal Dialysis 2.00 0 0 0.00 2.00 0.00 2.01 2.01 3.00 Training - Hemodialysis 0.00 3.00 Training - Peritoneal Dialysis Training - CAPD 4.00 0 0 0.00 4.00 5 00 0 00 5 00 Training - CCPD 0.00 6.00 6.00 Home Program - Hemodialysis Home Program - Peritoneal Dialysis 7.00 0.00 7.00 8.00 0.00 8.00 6.00 7.00 9.00 Home Program - CAPD 0.00 9. 00 Home Program - CCPD 10 00 0.00 10.00 Totals (sum of lines 1 through 8, cols. 1 11.00 201, 712 11.00 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction) Total treatments (sum of lines 1 through 8 12.00 12.00 plus (sum of lines 9 and 10 times 3)) (see instruction)

Heal th	Financial Systems PARIS COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	Provi der CCN: 14-1320	Peri od:	Worksheet I-5	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/23/2024 4: 0	1 pm
			1. 00	2. 00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII -				
1.00	Total expenses related to care of program beneficiaries (see i		1, 315, 585		1. 00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instr		201, 712	201, 712	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see in				2. 01
2. 02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see ins	tructions)			2. 02
2.03	Total payment due (see instructions)		201, 712	201, 712	2. 03
2.04	Outlier payments		140		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instruct	i ons)	0	0	3.00
3. 01	Deductibles billed to Medicare (Part B) patients (see instruct	i ons)			3. 01
3.02	Deductibles billed to Medicare (Part B) patients (see instruct	i ons)			3. 02
3.03	Total deductibles billed to Medicare (Part B) patients (see in	structions)	o	0	3. 03
4.00	Coinsurance billed to Medicare (Part B) patients	•	40, 417	40, 417	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instruct	i ons)	·	·	4. 01
4. 02	Coinsurance billed to Medicare (Part B) patients (see instruct				4. 02
4. 03	Total coinsurance billed to Medicare (Part B) patients (see in		40, 417	40, 417	4. 03
5. 00	Bad debts for deductibles and coinsurance, net of bad debt rec	,	0	0	5. 00
5. 01	Transition period 1 (75-25%) bad debts for deductibles and coi			ŭ.	5. 01
0.0.	recoveries for services rendered on or after 1/1/2011 but befo				0.0.
5. 02	Transition period 2 (50-50%) bad debts for deductibles and coi				5. 02
0.02	recoveries for services rendered on or after 1/1/2012 but befo				0.02
5. 03	Transition period 3 (25-75%) bad debts for deductibles and coi				5. 03
0.00	recoveries for services rendered on or after 1/1/2013 but befo				0.00
5. 04	100% PPS bad debts for deductibles and coinsurance net of bad		o	0	5. 04
	services rendered on or after 1/1/2014			-	
5.05	Allowable bad debts (sum of lines 5 through line 5.04)		ol	0	5. 05
6.00	Adjusted reimbursable bad debts (see instructions)		ol		6.00
7. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	o		7. 00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) pa	•	0	40, 417	8. 00
	instructions)				
9.00	Program payment (see instructions)		ol	161, 370	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			, , , , ,	10.00
11. 00	Reimbursable bad debts (see instructions) (transfer to Workshe	et E. Part B. line 33)	o		11. 00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERC		-		
12.00	Total allowable expenses (see instructions)		1, 315, 585		12.00
13. 00	Total composite costs (from Wkst. I-4, col. 2, line 11)		1, 315, 585		13. 00
14. 00	Facility specific composite cost percentage (line 13 divided b	v line 12)	1. 000000		14. 00
	PART III - ESRD PAYMENTS - INFORMATION ONLY	,			
15. 00	Low volume payment amount (see instructions)		0		15. 00
16. 00	TDAPA		Ö		16. 00
17. 00	TPNI ES		Ö		17. 00
18. 00	CRA TPNI ES		٥		18. 00
19. 00	HDPA				19. 00
20. 00			0		20. 00
20.00	li i n		١		20.00

Heal th	Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 14-1320	Peri od:	Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023		pared: 1 pm
					RHC I	Cost	
		Compensation	Other Costs		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	2.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2. 00	3.00	4.00	5.00	
1. 00	Physician	4, 056, 162	0	4, 056, 16	2 -51, 785	4, 004, 377	1.00
2. 00	Physician Assistant	4,030,102	0		-51, 765 N	4,004,377	2.00
3. 00	Nurse Practitioner	1, 344, 329	0	1, 344, 32	٥		
4. 00	Visiting Nurse	1, 544, 527	0	1, 544, 52	000	1, 545, 445	1
5. 00	Other Nurse	2, 087, 410	0	2, 087, 41		2, 087, 410	
6.00	Clinical Psychologist	0	0	2,007,11	0 0	2,007,110	1
7. 00	Clinical Social Worker	0	0		o o	Ō	
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	1, 361, 055	0	1, 361, 05	5 0	1, 361, 055	9. 00
10.00	Subtotal (sum of lines 1 through 9)	8, 848, 956	0	8, 848, 95	6 -52, 671	8, 796, 285	10.00
11. 00	Physician Services Under Agreement	0	0		0	0	1
12. 00	Physician Supervision Under Agreement	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	0	1	0	0	14. 00
15.00	Medical Supplies	0	14, 578	14, 57	8 0	14, 578	
16.00	Transportation (Health Care Staff)	0	0	1	0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0		0	0	17. 00
18.00	Professional Liability Insurance	0	203, 785			203, 785	
19.00	Other Heal th Care Costs	0	177, 987	177, 98	/ 0	177, 987	
20.00	Allowable GME Costs		20/ 250	20/ 25		20/ 250	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0.040.054	396, 350			396, 350	
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	8, 848, 956	396, 350	9, 245, 30	6 -52, 671	9, 192, 635	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICES	<u> </u>					1
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental		0			n	24. 00
25. 00	Optometry	0	0		o o	0	
25.00		1 0	0		- - - - - -	F2 471	

0

1, 155, 264

4, 613, 740

5, 769, 004

15, 014, 310

0

1, 155, 264

3, 234, 081

4, 389, 345

4, 785, 695

1, 379, 659

1, 379, 659

10, 228, 615

52, 671

52, 671

0

0

52, 671

1, 155, 264

4, 613, 740

5, 769, 004

15, 014, 310

25.01

25. 02

26. 00

27.00

28. 00

29.00

30.00

31.00

32.00

Tel eheal th

29.00 Facility Costs

and 31)

30)

Chronic Care Management

Nonallowable GME costs

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

All other nonreimbursable costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

25. 01

25. 02

26.00

27.00 28.00

31.00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1320	Period: Worksheet M-1 From 01/01/2023
	Component CCN: 14-3987	To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm

							5/23/2024 4:0)1 pm
						RHC I	Cost	
		Adjustments	Net I	Expenses				
			for Al	llocation				
			(col.	5 + col.				
				6)				
		6. 00		7. 00				
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0) 4	4, 004, 377				1. 00
2.00	Physician Assistant	0		0				2. 00
3.00	Nurse Practitioner	0) -	1, 343, 443				3. 00
4.00	Visiting Nurse	0		0				4.00
5.00	Other Nurse	0) :	2, 087, 410				5. 00
6.00	Clinical Psychologist	0	ol	0				6. 00
7.00	Clinical Social Worker	0		0				7. 00
7. 10	Marriage and Family Therapist		İ					7. 10
7. 11	Mental Health Counselor		İ					7. 11
8.00	Laboratory Techni ci an	0		0				8.00
9.00	Other Facility Health Care Staff Costs	0) -	1, 361, 055				9.00
10.00	Subtotal (sum of lines 1 through 9)	0		8, 796, 285				10.00
11. 00	Physician Services Under Agreement	0		0	1			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	ál	0				14. 00
15. 00	Medical Supplies	0	ál	14, 578				15. 00
16. 00	Transportation (Health Care Staff)	0	ál	0				16.00
17. 00	Depreciation-Medical Equipment	0	ál	0				17. 00
18. 00	Professional Liability Insurance	0	ál	203, 785				18. 00
19. 00	Other Health Care Costs	0	ál –	177, 987				19. 00
20. 00	Allowable GME Costs	0	Ί	177, 707				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0		396, 350				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	íl (9, 192, 635				22. 00
22.00	lines 10, 14, and 21)	O	Ί	9, 192, 000				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	ol .	0				23. 00
24. 00	Dental	0	ál	0				24. 00
25. 00	Optometry	0		0				25. 00
25. 01	Tel eheal th	0	ál	52, 671				25. 01
25. 02	Chronic Care Management	0	ál –	02, 07 1				25. 02
26. 00	All other nonreimbursable costs	0	()	0				26. 00
27. 00	Nonal Lowable GME costs	O	Ί	O				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	Ō		52, 671				28. 00
20.00	through 27)	U	Ί	52, 071				20.00
	FACILITY OVERHEAD		1					-
29 00	Facility Costs	0) .	1, 155, 264				29. 00
30.00	Administrative Costs	-265, 078		4, 348, 662				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-265, 078 -265, 078		5, 503, 926				31. 00
31.00	30)	-205,076	Ί	5, 505, 720				31.00
32. 00	Total facility costs (sum of lines 22, 28	-265, 078	1,	4, 749, 232				32. 00
32.00	and 31)	200,070	Ί '	1, 777, 232				32.00
	1=	!	1	1	1			

Heal th	Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component	CCN: 14-3989	From 01/01/2023 To 12/31/2023		
					RHC II	Cost	<u>. p</u>
	·	Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			1		_	
1. 00	Physi ci an	0	0		0	_	1.00
2.00	Physician Assistant	0	0		0	_	
3.00	Nurse Practitioner	250, 404	0	250, 40			1
4.00	Visiting Nurse	0	0		0	1	
5.00	Other Nurse	197, 435	0	197, 43			1
6.00	Clinical Psychologist	0	0		0	1	0.00
7.00	Clinical Social Worker	0	0		0	0	1.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor	_	_			_ '	7. 11
8.00	Laboratory Techni ci an	0	0		0	_	
9.00	Other Facility Health Care Staff Costs	0	0		0 0	1	1 7.00
10.00	Subtotal (sum of lines 1 through 9)	447, 839	0	447, 83			
11. 00	Physician Services Under Agreement	0	0		0		
12. 00	Physician Supervision Under Agreement	0	0		0	0	
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	1	1
15.00	Medical Supplies	0	4, 837	4, 83		.,	1
16.00	Transportation (Health Care Staff)	0	0		0	1	
17. 00	Depreciation-Medical Equipment	0	0		0	0	1
18.00	Professional Liability Insurance	0	10.150		0	0	18. 00
19.00	Other Health Care Costs	U	10, 153	10, 15	0	10, 153	1
20.00	Allowable GME Costs		44.000	44.00		44 000	20.00
21. 00	Subtotal (sum of lines 15 through 20)	447 000	14, 990			,	1
22. 00	Total Cost of Health Care Services (sum of	447, 839	14, 990	462, 82	-254	462, 575	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23. 00	Pharmacy	O	0	I	0 0	0	23. 00
24. 00	Dental	0	0		0 0	1	0.00
25. 00	Optometry		0		0 0	-	25.00
25. 00	Tel eheal th		0		0 254	1	25. 00
25. 01	Chronic Care Management		0		0 254		25. 01
26. 00	All other nonreimbursable costs		0		0 0		26. 00
	Nanal Lawahi a CME agata	١	U		ا		20.00

14, 044

152, 565

166, 609

181, 599

61, 257

61, 257

509, 096

254

14, 044

213, 822

227, 866

690, 695

254

0

0

14, 044

213, 822

227, 866

690, 695

27.00

28. 00

29.00

30.00

31.00

32.00

29.00 Facility Costs

and 31)

Nonallowable GME costs

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

27.00 28.00

31.00 32.00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS		Period: Worksheet M-1 From 01/01/2023
		To 12/31/2023 Date/Time Prepared:

			Component	CCN:	14-3989	То	12/31/2023	Date/Time Pro 5/23/2024 4:0	epared: 01 nm
							RHC II	Cost	ут риг
		Adjustments	Net Expenses					<u> </u>	
		f	or Allocation	n					
		([col. 5 + col.	.					
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS			_					
1.00	Physi ci an	0		0					1. 00
2.00	Physician Assistant	0		0					2. 00
3.00	Nurse Practitioner	0	250, 15	이					3. 00
4.00	Visiting Nurse	0		0					4. 00
5.00	Other Nurse	0	197, 43	1					5. 00
6.00	Clinical Psychologist	0		0					6.00
7.00	Clinical Social Worker	O	(O					7. 00
7. 10	Marriage and Family Therapist								7. 10
7. 11	Mental Health Counselor								7. 11
8.00	Laboratory Techni ci an	0		0					8. 00
9.00	Other Facility Health Care Staff Costs	0		0					9.00
10.00	Subtotal (sum of lines 1 through 9)	U O	447, 58	. 1					10.00
11.00	Physician Services Under Agreement	0		0 0					11. 00 12. 00
12.00	Physician Supervision Under Agreement	0		0					13. 00
13.00	Other Costs Under Agreement	0		0					14. 00
14. 00 15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	4, 83	- 1					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								18. 00
19. 00	Other Health Care Costs	0	10, 15	2					19. 00
20. 00	Allowable GME Costs	o o	10, 15	٦					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	14. 99						21. 00
22. 00	Total Cost of Health Care Services (sum of	0	462, 57	- 1					22. 00
22.00	lines 10, 14, and 21)	٩	402, 37	٦					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			-					
23.00	Pharmacy	0		o					23. 00
24.00	Dental	O	(ol					24. 00
25.00	Optometry	0	(ol					25. 00
25. 01	Tel eheal th	0	25	4					25. 01
25. 02	Chronic Care Management	0	(o					25. 02
26.00	All other nonreimbursable costs	0	(o					26. 00
27. 00	Nonallowable GME costs								27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	25	4					28. 00
	through 27)								
	FACILITY OVERHEAD								
29. 00	Facility Costs	0	14, 04						29. 00
30. 00	Administrative Costs	-734	213, 08	1					30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-734	227, 13	2					31. 00
	30)								
32. 00	Total facility costs (sum of lines 22, 28	-734	689, 96	7					32. 00
	and 31)			1					1

Heal th	Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Li€	eu of Form CMS-:	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023		nared:
			Component	CCN. 14-0370	10 12/31/2023	5/23/2024 4:0	
					RHC III	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	388, 592	C	388, 59	02 0	388, 592	1.00
2.00	Physician Assistant	0	C		0 0	0	2. 00
3.00	Nurse Practitioner	119, 453	C	119, 45	-946	118, 507	3. 00
4.00	Visiting Nurse	0	C		0 0	0	4. 00
5.00	Other Nurse	84, 259	C	84, 25	0	84, 259	5. 00
6.00	Clinical Psychologist	0	C)	0	0	6. 00
7.00	Clinical Social Worker	0	C)	0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	C)	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	E02 204	C	E00 20	-946	0	9.00
10. 00 11. 00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	592, 304		592, 30	-940	591, 358 0	10. 00 11. 00
12. 00	Physician Supervision Under Agreement	0				0	12.00
13. 00	Other Costs Under Agreement	0			0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)					0	14. 00
	Medical Supplies		207	20	17	-	15 00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-1320	Period: Worksheet M-1 From 01/01/2023
	Component CCN: 14-8596	To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm

			Component	CCN. 14-0590	10	12/31/2023	5/23/2024 4:	
						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	388, 592					1. 00
2.00	Physician Assistant	0	0					2. 00
3.00	Nurse Practitioner	0	118, 507					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	84, 259					5. 00
6.00	Clinical Psychologist	0	0					6. 00
7.00	Clinical Social Worker	0	0					7. 00
7. 10	Marriage and Family Therapist							7. 10
7. 11	Mental Health Counselor							7. 11
8.00	Laboratory Techni ci an	0	0	•				8. 00
9.00	Other Facility Health Care Staff Costs	0	0					9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	591, 358	1				10. 00
11. 00	Physician Services Under Agreement	0	0	1				11. 00
12. 00	Physician Supervision Under Agreement	0	0	1				12. 00
13. 00	Other Costs Under Agreement	0	0	1				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	1				14. 00
15. 00	Medical Supplies	0	207	1				15. 00
16. 00	Transportation (Health Care Staff)	0	0	l .				16. 00
17. 00	Depreciation-Medical Equipment	0	0	1				17. 00
18. 00	Professional Liability Insurance	0	9, 576	•				18. 00
19. 00	Other Health Care Costs	0	10, 053					19. 00
20.00	Allowable GME Costs		40.007					20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	19, 836	1				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	611, 194					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	1				24. 00
25. 00	Optometry	0	0	1				25. 00
25. 00	Tel eheal th	0	946	•				25. 00
25. 01	Chronic Care Management	0	940	1				25. 01
26. 00	All other nonreimbursable costs	0	0	1				26. 00
27. 00	Nonallowable GME costs	O	0					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	946					28. 00
20.00	through 27)	U	740					28.00
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	23, 237					29. 00
30.00	Administrative Costs	-3, 197	142, 653	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-3, 197	165, 890	1				31. 00
	30)	-, . , ,	, 0 , 0					
32.00	Total facility costs (sum of lines 22, 28	-3, 197	778, 030					32. 00
	and 31)							

Heal th	Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
					RHC IV	Cost	т рііі
		Compensation	Other Costs	Total (col. 1	Reclassificati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physi ci an	328, 312	0	328, 31	2 0	328, 312	1.00
2. 00	Physician Assistant	020,012	0	020,01	0 0	0	2. 00
3. 00	Nurse Practitioner	941, 564	Ö	941, 56	4 -295	941, 269	3. 00
4.00	Visiting Nurse	0	0	·	0 0	0	4. 00
5.00	Other Nurse	321, 591	0	321, 59	1 0	321, 591	5. 00
6.00	Clinical Psychologist	0	0		0 0	0	6. 00
7.00	Clinical Social Worker	0	0		0 0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	429, 903		429, 90		1277700	
10.00	Subtotal (sum of lines 1 through 9)	2, 021, 370	0	2, 021, 37	0 -295		1
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12. 00 13. 00	Physician Supervision Under Agreement Other Costs Under Agreement	0	0		0	0	12. 00 13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0			0	0	14.00
15. 00	Medical Supplies	0	13, 912	13, 91	2 0	13, 912	1
16. 00	Transportation (Health Care Staff)	0	13, 712	13, 71	0 0	13, 712	1
17. 00	Depreciation-Medical Equipment	0	0		0 0		17. 00
18. 00	Professional Liability Insurance	0	27, 288	27, 28	8 0	27, 288	
19. 00	, and the second	0	56, 765			56, 765	1
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	97, 965	97, 96	5 0	97, 965	21. 00
22. 00	Total Cost of Health Care Services (sum of	2, 021, 370	97, 965	2, 119, 33	5 -295	2, 119, 040	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0	1	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			0 295	295	1
25. 02 26. 00	9				0	0	25. 02 26. 00
	Nanal Lawahi a CME agata		١	1	٠ ا		20.00

262, 910

262, 910

2, 284, 280

295

19, 810

1, 093, 843

1, 113, 653

3, 232, 988

27.00

28. 00

29.00

30.00

31.00

32.00

0

295

0

19, 810

1, 093, 843

1, 113, 653

3, 232, 988

19, 810

830, 933

850, 743

948, 708

32.00 Total facility costs (sum of lines 22, 28

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Nonallowable GME costs

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

30)

27.00 28. 00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1320	Period: Worksheet M-1 From 01/01/2023
	Component CCN: 14-8607	To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm

			Component	CCN. 14-0007	10	12/31/2023	5/23/2024 4:	
						RHC IV	Cost	
		Adjustments	Net Expenses					
			for Allocation	ı				
			(col. 5 + col.					
			6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	328, 312	2				1. 00
2.00	Physician Assistant	0	C)				2. 00
3.00	Nurse Practitioner	0	941, 269	·[3. 00
4.00	Visiting Nurse	0	C)				4. 00
5.00	Other Nurse	0	321, 591					5. 00
6.00	Clinical Psychologist	0	C)				6. 00
7.00	Clinical Social Worker	0	C)				7. 00
7. 10	Marriage and Family Therapist							7. 10
7. 11	Mental Health Counselor							7. 11
8.00	Laboratory Techni ci an	0	C)				8. 00
9.00	Other Facility Health Care Staff Costs	0	429, 903					9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	2, 021, 075	1				10. 00
11. 00	Physician Services Under Agreement	0	C	1				11. 00
12. 00	Physician Supervision Under Agreement	0	C	•				12. 00
13. 00	Other Costs Under Agreement	0	C	1				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	C	1				14. 00
15. 00	Medical Supplies	0	13, 912	1				15. 00
16. 00	Transportation (Health Care Staff)	0	C	1				16. 00
17. 00	Depreciation-Medical Equipment	0	0	1				17. 00
18. 00	Professional Liability Insurance	0	27, 288	1				18. 00
19. 00	Other Health Care Costs	0	56, 765					19. 00
20.00	Allowable GME Costs		07.045					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	97, 965	1				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	2, 119, 040	9				22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES							-
23. 00	Pharmacy	٥	C	<u>, </u>				23. 00
24. 00	Dental	0	(1				24. 00
25. 00	Optometry	0	(1				25. 00
25. 00	Tel eheal th	0	295	1				25. 00
25. 01	Chronic Care Management	0	275	•				25. 01
26. 00	All other nonreimbursable costs	0	(1				26. 00
27. 00	Nonallowable GME costs	ď		'				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	295					28. 00
20.00	through 27)	o o	270	'				20.00
	FACILITY OVERHEAD							1
29. 00	Facility Costs	ol	19, 810					29. 00
30.00	Administrative Costs	-349	1, 093, 494	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-349	1, 113, 304	1				31.00
	30)		.,					
32.00	Total facility costs (sum of lines 22, 28	-349	3, 232, 639	•				32. 00
	and 31)							

Heal th	Financial Systems	PARIS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-:	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
					RHC V	Cost	
		Compensation	Other Costs		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	3, 692	0	3, 69	2 0	3, 692	1.00
2.00	Physician Assistant	0,072	0	3, 37	0 0		1
3.00	Nurse Practitioner	339, 230	0	339, 23		339, 230	
4. 00	Visiting Nurse	0	0		o o	0	4. 00
5.00	Other Nurse	50, 620	0	50, 62	0	50, 620	
6.00	Clinical Psychologist	0	0		0 0	0	6. 00
7.00	Clinical Social Worker	o	0	1	0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	70, 901	0	70, 90		70, 901	
10.00	Subtotal (sum of lines 1 through 9)	464, 443	0	464, 44		464, 443	
11. 00	Physician Services Under Agreement	0	0		0	0	
12.00	Physician Supervision Under Agreement	0	0		0	0	
13. 00	Other Costs Under Agreement	0	0	1	0	0	10.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	
15.00	Medical Supplies	0	4, 023	4, 02		4, 023	
	Transportation (Health Care Staff)	0	0		0 0	0	
17. 00 18. 00	Depreciation-Medical Equipment Professional Liability Insurance	0	40, 524	40, 52	0	0 40, 524	
	Other Health Care Costs	0	40, 524	40, 52	0 0	l	1
	Allowable GME Costs	U U	U	1	U U	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)		44, 547	44, 54	7 0	44, 547	
	Total Cost of Health Care Services (sum of	464, 443	44, 547			508, 990	
22.00	lines 10, 14, and 21)	404, 443	44, 347	300, 77	0	300, 770	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			1
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	Ö	0		o o	Ō	
25. 00	Optometry	0	O		0	0	25. 00
25. 01	Tel eheal th	0	O		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00

39, 683

39, 683

504, 126

16, 287 111, 089

127, 376

171, 923

16, 287

150, 772

167, 059

676, 049

27.00

28. 00

29.00

30.00

31.00

32.00

16, 287 150, 772

167, 059

676, 049

0

27.00 Nonallowable GME costs

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

28. 00

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 01/01/2023
	Component CCN: 14-8606	To 12/31/2023 Date/Time Prepared: 5/23/2024 4:01 pm

			Component	CCIN:	14-8606	10	12/31/2023	5/23/2024 4:	
							RHC V	Cost	<u> </u>
		Adjustments	Net Expenses						
		-	for Allocation	า					
			(col. 5 + col.	.					
			6)						
		6.00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS	ام	0.70	al .					
1.00	Physi ci an	0	3, 692						1.00
2.00	Physician Assistant	0							2.00
3.00	Nurse Practitioner	U O	339, 230						3.00
4. 00 5. 00	Visiting Nurse Other Nurse	U O	50, 620						4. 00 5. 00
6. 00	Clinical Psychologist	0	30, 620						6. 00
7. 00	Clinical Social Worker	0	(2					7. 00
7. 10	Marriage and Family Therapist	ď	,	7					7. 10
7. 10	Mental Health Counselor								7. 11
8.00	Laboratory Techni ci an	0	(ol					8. 00
9. 00	Other Facility Health Care Staff Costs	ol	70, 90 ⁻	-1					9. 00
10.00	Subtotal (sum of lines 1 through 9)	ol	464, 443						10.00
11. 00	Physician Services Under Agreement	ol		ol o					11. 00
12. 00	Physician Supervision Under Agreement	o	(ol					12. 00
13.00	Other Costs Under Agreement	o	(ol					13.00
14.00	Subtotal (sum of lines 11 through 13)	o	(o					14. 00
15.00	Medical Supplies	o	4, 023	3					15. 00
16.00	Transportation (Health Care Staff)	0	(o					16. 00
17. 00	Depreciation-Medical Equipment	0) C					17. 00
18. 00	Professional Liability Insurance	0	40, 52	4					18. 00
19. 00	Other Health Care Costs	0	() C					19. 00
20. 00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	44, 54						21. 00
22. 00	Total Cost of Health Care Services (sum of	0	508, 990)					22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES								
23. 00	Pharmacy	ol							23. 00
24. 00	Dental	0		0					24. 00
25. 00	Optometry	0							25. 00
25. 00	Tel eheal th	o O		0					25. 01
25. 02	Chronic Care Management	Ö		0					25. 02
26. 00	All other nonreimbursable costs	ol	(o l					26. 00
27. 00	Nonallowable GME costs	آ ا							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	(ol					28. 00
	through 27)								
	FACILITY OVERHEAD						·		
29. 00	Facility Costs	0	16, 28						29. 00
30.00	Administrative Costs	-1, 563	149, 209						30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-1, 563	165, 496	6					31. 00
22.00	30)	1 5/0	/74 40	,					22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	-1, 563	674, 486	b					32. 00
	and 31)	ı		1					ı

Uool +h	Financial Systems	PARIS COMMUNIT	TV HOSDITAL		In Lie	eu of Form CMS-:	2552 10
	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	PARTS COMMUNIT	Provider C	CN: 14-1320	Peri od:	Worksheet M-1	
THATE	NO CHARGO THE BROOK MICH THE GOOD			CCN: 15-8573	From 01/01/2023 To 12/31/2023		pared:
					RHC VI	Cost	т ріп
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
		'		+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			1		1	
1.00	Physi ci an	0	0		0 0		
2.00	Physician Assistant	0	0	1	0 0		
3.00	Nurse Practitioner	0	0		0 0	-	3.00
4.00	Visiting Nurse	0	0		0 0	0	4. 00 5. 00
5. 00 6. 00	Other Nurse	0	0		0 0	0	
7. 00	Clinical Psychologist Clinical Social Worker	0	0		0	0	
7. 10	Marriage and Family Therapist	U	C			0	7. 10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	0	,	0	0	
9. 00	Other Facility Health Care Staff Costs	o o	Ö		0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	l ol	0	,	o o	l o	10.00
11. 00	Physician Services Under Agreement	o	0	,	o o	Ō	1
12. 00		O	O)	0 0	0	12.00
13.00	Other Costs Under Agreement	O	0	1	0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0)	0 0	0	14. 00
15.00	Medical Supplies	0	0)	0 0	0	15. 00
	Transportation (Health Care Staff)	0	0	1	0	0	1
	Depreciation-Medical Equipment	0	0)	0	0	1
	Professional Liability Insurance	0	0	1	0	0	
19. 00		0	O	1	0	0	19. 00
20.00							20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	Ü		0 0		
22. 00		0	0	1	0 0	0	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		0	0	1	0 0	0	23. 00
24. 00	Dental		0			-	
25. 00			0			0	
25. 01	Tel eheal th	ا	Ö			0	
	Chronic Care Management	l	0	,	0 0	l o	1
26. 00	All other nonreimbursable costs	o	0		0 0	Ō	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

1, 423

1, 423

1, 423

1, 423

1, 423

1, 423

0

29. 00 30. 00

31.00

32.00

1, 423

1, 423

1, 423

32.00 Total facility costs (sum of lines 22, 28

Total Facility Overhead (sum of lines 29 and 30)

through 27)
FACILITY OVERHEAD
Facility Costs
30.00 Administrative Costs

and 31)

Health Financial Systems	PARIS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1320	Peri od: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8573		

			Component	CCN. 13-0	0373	10	12/31/2023	5/23/2024 4:	
							RHC VI	Cost	<u> </u>
		Adjustments	Net Expenses						
			for Allocation	n					
			(col. 5 + col.						
			6)						
		6.00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	()					1. 00
2.00	Physician Assistant	0	(ol					2. 00
3.00	Nurse Practitioner	0	(3. 00
4.00	Visiting Nurse	0	(4. 00
5.00	Other Nurse	0	(ol					5. 00
6.00	Clinical Psychologist	0	(ol					6. 00
7.00	Clinical Social Worker	0	(ol					7. 00
7. 10	Marriage and Family Therapist								7. 10
7. 11	Mental Health Counselor								7. 11
8.00	Laboratory Techni ci an	0	(ol					8. 00
9.00	Other Facility Health Care Staff Costs	0	(ol					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	(ol					10.00
11. 00	Physician Services Under Agreement	0	(11. 00
12. 00	Physician Supervision Under Agreement	0	(12. 00
13.00	Other Costs Under Agreement	0							13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	(14. 00
15. 00	Medical Supplies	0	(15. 00
16. 00	Transportation (Health Care Staff)	0	(16, 00
17. 00	Depreciation-Medical Equipment	0	(17. 00
18. 00	Professional Liability Insurance	0	(18. 00
19. 00	Other Health Care Costs	0	(19. 00
20. 00	Allowable GME Costs	-							20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	(21. 00
22. 00	Total Cost of Health Care Services (sum of	0	(22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	(23. 00
24.00	Dental	0	(24. 00
25.00	Optometry	0	(25. 00
25. 01	Tel eheal th	0	(25. 01
25. 02	Chronic Care Management	0	(25. 02
26.00	All other nonreimbursable costs	0	(26. 00
27.00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	(28. 00
	through 27)								
	FACILITY OVERHEAD			•					
29. 00	Facility Costs	0	(29. 00
30.00	Administrative Costs	0	1, 423	3					30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	o	1, 423	1					31.00
	30)								
32.00	Total facility costs (sum of lines 22, 28	0	1, 423	3					32. 00
	and 31)								1

	Financial Systems	PARIS COMMUNI				u of Form CMS-2	
4LLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQH	C SERVI CES	Provider CO		Period: From 01/01/2023	Worksheet M-2	
			Component (o 12/31/2023	Date/Time Pre	pared:
			· ·			5/23/2024 4: 0	1 pm
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)		
		1. 00	2.00	3. 00	4.00	5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	3.00	
	Posi ti ons						i
1. 00	Physi ci an	7. 08	29, 615	4, 200	29, 736		1.00
2. 00	Physician Assistant	0. 00					2.00
3. 00	Nurse Practitioner	6. 61		•			3.00
4. 00	Subtotal (sum of lines 1 through 3)	13. 69		,	43, 617	47, 801	4.00
5. 00	Visiting Nurse	0. 00				0	5.00
6. 00	Clinical Psychologist	0. 00				ol	6.00
7. 00	Clinical Social Worker	0. 00				o	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				o	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			ol	7. 02
	only)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8. 00	Total FTEs and Visits (sum of lines 4	13. 69	47, 801			47, 801	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL BASE	D BHC/EOHC SEB	VICES		1. 00	
10. 00	Total costs of health care services (from			V1 020		9, 192, 635	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-					52, 671	
12. 00	Cost of all services (excluding overhead)					9, 245, 306	
13. 00	Ratio of hospital -based RHC/FQHC services					0. 994303	
14. 00	Total hospital-based RHC/FQHC overhead - (ne 31)		5, 503, 926	
15. 00	Parent provider overhead allocated to faci			/		2, 062, 777	
16. 00	Total overhead (sum of lines 14 and 15)	., (7, 566, 703	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					7, 566, 703	
	Overhead applicable to hospital-based RHC/	FOHC services (Li	ne 13 x line 1	8)		7, 523, 595	

	Financial Systems	PARIS COMMUNI				u of Form CMS-2	
ALLOCAT	ION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der CO		Period: From 01/01/2023	Worksheet M-2	
			Component (To 12/31/2023	Date/Time Pre	pared:
						5/23/2024 4:0	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1. 00	2. 00	3. 00	4, 00	5. 00	
V	/ISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	3.00	
	Positions						i
_	Physi ci an	0.00	0	4, 20	0 0		1.00
- 1	Physician Assistant	0.00	0				2.00
3.00 1	Nurse Practitioner	1. 35	3, 942	2, 10	0 2, 835		3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 35	3, 942		2, 835	3, 942	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
	Medical Nutrition Therapist (FQHC only)	0. 00				0	7. 0°
	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
	onl y)						
	Marriage and Family Therapist						7. 03
	Mental Health Counselor	1 25	2 042			2.042	7.04
	Total FTEs and Visits (sum of lines 4	1. 35	3, 942			3, 942	8.00
	through 7) Physician Services Under Agreements		0			0	9.00
7. 00 I	Friysi Crair Servi Ces Under Agreements		0			0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from W	st. M-1, col. 7	', line 22)			462, 575	10.00
	Total nonreimbursable costs (from Wkst. M-1,					254	11.00
	Cost of all services (excluding overhead) (s					462, 829	
	Ratio of hospital-based RHC/FQHC services (I					0. 999451 227, 132	13. 00 14. 00
	Parent provider overhead allocated to facili	ty (see instruc	ctions)			177, 229	
	Total overhead (sum of lines 14 and 15)					404, 361	16.00
	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16		40 11 4	0)		404, 361	18.00
	Overhead applicable to hospital-based RHC/FC					404, 139	
20.00	Total allowable cost of hospital-based RHC/F	·UHC services (s	sum of lines 10	and 19)		866, 714	J 20. 00

	Financial Systems	PARIS COMMUNI				u of Form CMS-2	
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der CO		Period: From 01/01/2023	Worksheet M-2	
			Component (Γο 12/31/2023	Date/Time Pre 5/23/2024 4:0	
					RHC III	Cost	
	·	Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						ļ
	Posi ti ons						
1. 00	Physi ci an	0. 25					1.00
2. 00	Physician Assistant	0. 00		_,			2.00
3.00	Nurse Practitioner	0. 30					3.00
4. 00	Subtotal (sum of lines 1 through 3)	0. 55			1, 680	1, 940	4.00
5. 00	Visiting Nurse	0. 00				0	5.00
6. 00	Clinical Psychologist	0. 00				0	6.00
7. 00	Clinical Social Worker	0.00	0			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)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8. 00	Total FTEs and Visits (sum of lines 4	0. 55	1, 940			1, 940	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BASE	D RHC/FQHC SER	VI CES			
10. 00	Total costs of health care services (from W	/kst. M-1, col. 7	7, line 22)			611, 194	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1	, col. 7, line 2	28)			946	11. 00
12. 00	Cost of all services (excluding overhead) (sum of lines 10	and 11)			612, 140	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (line 10 divided	by line 12)			0. 998455	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (f	rom Worksheet. N	Λ-1, col. 7, li	ne 31)		165, 890	14.00
15. 00	Parent provider overhead allocated to facil			•		108, 814	15. 00
16. 00	Total overhead (sum of lines 14 and 15)	•	•			274, 704	16.00
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					274, 704	18.00
19. 00	Overhead applicable to hospital-based RHC/F	QHC services (li	ne 13 x line 1	8)		274, 280	19.00
	Total allowable cost of hospital-based RHC/			*		885, 474	

	Financial Systems	PARIS COMMUNI				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der CO		Peri od:	Worksheet M-2	
			Component (From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
					RHC IV	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 37					1.00
2.00	Physi ci an Assi stant	0. 00		_,			2. 00
3.00	Nurse Practitioner	4. 88	· ·	2, 10			3. 00
4.00	Subtotal (sum of lines 1 through 3)	5. 25			11, 802	20, 407	4.00
5.00	Visiting Nurse	0. 00				0	5. 00
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. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7.03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	5. 25	20, 407			20, 407	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES		1.00	
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	', line 22)			2, 119, 040	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	18)			295	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			2, 119, 335	12.00
13.00							
14.00	.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						
15.00	Parent provider overhead allocated to facili	ty (see instruc	tions)			1, 038, 924	15. 00
16.00						2, 152, 228	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					2, 152, 228	
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		2, 151, 929	19. 00
20 00	Total allowable cost of hospital-based RHC/F	OUC corvinge (c	um of lines 10	and 10)		4, 270, 969	1 20 00

	Financial Systems	PARIS COMMUNI				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider CO		Period: From 01/01/2023	Worksheet M-2	
			Component (Γο 12/31/2023	Date/Time Pre 5/23/2024 4:0	
					RHC V	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		4.00	0.00	0.00	3)	4	
	VICITO AND DECENICATIVITY	1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Positions Physician	0.07	211	4 200	204		1 1 00
1.00	Physician	0. 07		4, 200			1.00
2.00	Physician Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	1. 95		2, 100			3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 02	· ·		4, 389		4.00
5.00	Visiting Nurse	0.00				0	5.00
5.00	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. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
7. 03	only) Marriage and Family Therapist						7. 03
7. 03 7. 04	Mental Health Counselor						7.03
7. 04 8. 00	Total FTEs and Visits (sum of lines 4	2. 02	6, 767			6, 767	8.00
8.00	through 7)	2.02	0, /0/			0, 707	8.00
9. 00	Physician Services Under Agreements		_			0	9.00
7.00	Triysi ci air Sei vi ces blider Agreements		0			0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			VI CES			
10. 00	Total costs of health care services (from Wk					508, 990	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	
12. 00	Cost of all services (excluding overhead) (s					508, 990 1. 000000	
13. 00							
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		165, 496	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	tions)			179, 963	
16. 00	Total overhead (sum of lines 14 and 15)					345, 459	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					345, 459	
	Overhead applicable to hospital-based RHC/FC	•		•		345, 459	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (s	um of lines 10	and 19)		854, 449	20.00

CAL CIT	Financial Systems PARIS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provi der CCN: 14-1320	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (Component CCN: 14-3987	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	pared:
		Title XVIII	RHC I	Cost	
			•	1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		16, 716, 230	1.00
2.00	Cost of injections/infusions and their administration (from W			573, 655	
3.00	Total allowable cost excluding injections/infusions (line 1 mi	inus line 2)		16, 142, 575	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	Lino (1)		47, 801 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	1111e 7)		47, 801	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			337. 70	
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1.00	12/31/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1. 00	2. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)	e or your contractor,	0.00	321. 40	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		0	11, 079	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra	•	0	3, 560, 791 313	1
13. 00	Program covered cost from mental health services (line 9 x lines)		0	100, 598	
14.00	Limit adjustment for mental health services (see instructions)	*	0	100, 598	
15.00	Graduate Medical Education Pass Through Cost (see instructions	•			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	3, 661, 389	
16. 01 16. 02	Total program charges (see instructions)(from contractor's real Total program preventive charges (see instructions)(from provi			2, 265, 441 58, 286	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	-		94, 200	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		2, 693, 838	16. 04
1/ 05	(Titles V and XIX see instructions.)			2 700 020	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	2, 788, 038	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		199, 891	18. 00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		398, 888	19. 00
20. 00	records) Net program cost excluding injections/infusions (see instructi	ions)		2, 788, 038	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.			239, 627	
21. 50	Total program IOP OPPS payments (see instructions)				21. 50
21. 55	, ,				21. 55
21. 60 22. 00	Program IOP deductible and coinsurance (see instructions) Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus lina 21 60)		3, 027, 665	21.60
	Allowable bad debts (see instructions)	iii iids 111ie 21.00)		92, 521	
23. 01	Adjusted reimbursable bad debts (see instructions)			60, 139	1
24. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		76, 045	1
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-)		0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	5)		0	
26. 00	Net reimbursable amount (see instructions)			3, 087, 804	
26. 01	Sequestration adjustment (see instructions)			61, 756	1
26. 02	Demonstration payment adjustment amount after sequestration			0	
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			2, 690, 829 0	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02. 27. and 28)		335, 219	
30.00	Protested amounts (nonallowable cost report items) in accordan			0	30.00

CALCUI	Financial Systems PARIS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	HOSPITAL Provider CCN: 14-1320	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (Component CCN: 14-3989	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:0	pared:
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			866, 714	1. 00
2. 00 3. 00	Cost of injections/infusions and their administration (from WI Total allowable cost excluding injections/infusions (line 1 mi			84, 328 782, 386	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	ilius IIIIe 2)		3, 942	4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			3, 942	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	198.47 of limit (1)	7. 00
			our cur a troir	01 21 1111 (1)	
				Rate Period 1	
			N/A	(01/01/2023 through	
				12/31/2023)	
0.00	D 111 1 (C 0)CD 1 100 04 1 1 0 0 C00	/	1.00	2.00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. Rate for Program covered visits (see instructions)	.6 or your contractor)	0. 00 0. 00	236. 66 198. 47	1
7. 00	CALCULATION OF SETTLEMENT		0.00	170. 17	7.00
10.00	Program covered visits excluding mental health services (from		0	435	
11. 00 12. 00	Program cost excluding costs for mental health services (line	•	0	86, 334 0	1
13. 00	Program covered visits for mental health services (from contra Program covered cost from mental health services (line 9 x line		0	0	
14. 00	Limit adjustment for mental health services (see instructions)	*	0	0	14. 00
15.00	Graduate Medical Education Pass Through Cost (see instructions	•		0, 00,	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 red		0	86, 334 77, 014	
16. 02	Total program preventive charges (see instructions)(from provi			5, 460	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	· ·		6, 121	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0%) (Titles V and XIX see instructions.)	3 and 18) times .80)		53, 476	16. 04
16. 05	Total program cost (see instructions)		0	59, 597	16. 05
17. 00	Pri mary payer amounts			32	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		13, 368	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		11, 598	19. 00
20. 00	Net program cost excluding injections/infusions (see instructi	ions)		59, 565	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		22, 825	
21. 50 21. 55	Total program IOP OPPS payments (see instructions) Total program IOP Costs (see instructions)				21. 50 21. 55
21. 60	Program IOP deductible and coinsurance (see instructions)				21.60
22. 00		minus line 21.60)		82, 390	
	Allowable bad debts (see instructions)				23. 00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		2, 291 2, 600	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 40 (1 0113)		0	1
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 84, 681	
26. 00	Sequestration adjustment (see instructions)			1, 694	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			50, 637	
28. 00 29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.0	02 27 and 28)		0 32, 350	28. 00 29. 00
27. UU	Protested amounts (nonallowable cost report items) in accordan	•		32, 330	30.00

	cial Systems PARIS COMMUNITY OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	HOSPITAL Provider CCN: 14-1320	In Lie	u of Form CMS-2 Worksheet M-3	
SERVI CES	5. N.E. 1155 N.E. 21 N	Component CCN: 14-8596	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		Title XVIII	RHC III	5/23/2024 4: 0° Cost	т рііі
DETERM	ALNATION OF DATE FOR HOCKITAL DACED DUC/FOUR CERVILORS			1. 00	
	MINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M-2 line 20)		885, 474	1.00
	of injections/infusions and their administration (from W			62, 702	1
4	allowable cost excluding injections/infusions (line 1 m	inus line 2)		822, 772	1
1	Visits (from Wkst. M-2, column 5, line 8)	1: 0)		1, 940	1
1 -	cians visits under agreement (from Wkst. M-2, column 5, adjusted visits (line 4 plus line 5)	Title 9)		0 1, 940	
	ted cost per visit (line 3 divided by line 6)			424. 11	1
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1. 00	12/31/2023)	
8.00 Per v	isit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	2. 00 371. 66	8. 00
1	for Program covered visits (see instructions)		0.00		1
	LATION OF SETTLEMENT			455	
	am covered visits excluding mental health services (from am cost excluding costs for mental health services (line		0	455 169, 105	1
	am covered visits for mental health services (from contr	*	0	107, 103	1
1 0	am covered cost from mental health services (line 9 x li	•	0	0	13. 00
1	adjustment for mental health services (see instructions	•	0	0	
	ate Medical Education Pass Through Cost (see instruction Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	169, 105	15. 00 16. 00
1	program charges (see instructions) (from contractor's re			77, 555	1
1	program preventive charges (see instructions)(from prov	•		6, 540	1
	program preventive costs ((line 16.02/line 16.01) times	•		14, 260	1
	Program non-preventive costs ((line 16 minus lines 16.0 es V and XIX see instructions.)	3 and 18) times .80)		114, 500	16. 04
	program cost (see instructions)		0	128, 760	16. 05
1	ry payer amounts			0	
18. 00 Less:	Beneficiary deductible for RHC only (see instructions)	(from contractor		11, 720	18. 00
	iciary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		11, 859	19. 00
	rogram cost excluding injections/infusions (see instruct	•		128, 760	
	am cost of vaccines and their administration (from Wkst.	M-4, line 16)		33, 831	1
1	program IOP OPPS payments (see instructions) program IOP Costs (see instructions)				21. 50
4	am IOP deductible and coinsurance (see instructions)				21. 60
1	reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		162, 591	1
1	able bad debts (see instructions)				23. 00
1 -	ted reimbursable bad debts (see instructions) able bad debts for dual eligible beneficiaries (see inst	ructions)		1, 369 1, 925	23. 01
1	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	1
	er ACO demonstration payment adjustment (see instruction	s)		0	
1	stration payment adjustment amount before sequestration eimbursable amount (see instructions)			0 163, 960	
	stration adjustment (see instructions)			3, 279	
26. 02 Demon	stration payment adjustment amount after sequestration			0	26. 02
27.00 Inter				121, 335	1
	tive settlement (for contractor use only) ce due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		0 39 346	28. 00 29. 00
1	sted amounts (nonallowable cost report items) in accorda	•		39, 340	
	er I, §115.2	•			

	Financial Systems PARIS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 14-1320	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (ES	Component CCN: 14-8607	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
		Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			4, 270, 969	1.00
2. 00 3. 00	Cost of injections/infusions and their administration (from WI Total allowable cost excluding injections/infusions (line 1 m			4, 305 4, 266, 664	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	riius i riie 2)		20, 407	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)			20, 407	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	209.08 of Limit (1)	7. 00
			Rate Period N/A	Rate Period 1 (01/01/2023	
			IN/ A	through	
				12/31/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1. 00	2. 00 343. 44	8. 00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	0.00		
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	•	0		
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra		0	593, 578 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x lines)		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction:	,	0	593, 578	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	848, 642	
16. 02	Total program preventive charges (see instructions)(from prov	•		22, 218	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	-		15, 540	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0) (Titles V and XIX see instructions.)	3 and 18) times .80)		422, 383	16. 04
16. 05	Total program cost (see instructions)		0	437, 923	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		50, 059	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		155, 080	19. 00
20. 00	Net program cost excluding injections/infusions (see instruct	*		437, 923	1
21. 00 21. 50	Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions)	M-4, line 16)		2, 551	21. 00 21. 50
21. 55	Total program IOP Costs (see instructions)				21. 50
21. 60	Program IOP deductible and coinsurance (see instructions)				21.60
22. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus line 21.60)		440, 474	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			14, 614 9, 499	1
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		10, 895	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50	Prioneer ACO demonstration payment adjustment (see instructions	s)		0	
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 449, 973	
26. 01	Sequestration adjustment (see instructions)			8, 999	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			391, 531 0	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02. 27. and 28)		49, 443	
30.00	Protested amounts (nonallowable cost report items) in accordan		1	0	

	Financial Systems PARIS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	HOSPITAL Provider CCN: 14-1320	In Lie	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 14-8606	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		Title XVIII	RHC V	5/23/2024 4: 0 Cost	1 pm
		THE ATTE	100 0	0031	
	DETERMINATION OF DATE FOR HOCKLIAN DAGED BUG (FOUR CERTIFICIES			1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst M-2 line 20)		854, 449	1.00
2. 00	Cost of injections/infusions and their administration (from W			034, 447	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		854, 449	1
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 0)		6, 767 0	4. 00 5. 00
6.00	Total adjusted visits (line 4 plus line 5)	11116 7)		6, 767	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			126. 27	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through 12/31/2023)	
			1. 00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	132. 33	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	126. 27	9.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	628	10.00
11. 00	Program cost excluding costs for mental health services (line	•	0	79, 298	
12. 00 13. 00	Program covered visits for mental health services (from contribution program covered cost from mental health services (line 9 x li	-	0	0	12. 00 13. 00
14. 00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction				15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	79, 298	
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		103, 554 5, 322	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		4, 075	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		50, 006	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	54, 081	16. 05
17. 00	Primary payer amounts			230	1
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		12, 715	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		17, 033	19. 00
19.00	records)	ns) (110m contractor		17,033	19.00
20. 00	Net program cost excluding injections/infusions (see instruct			53, 851	
21. 00 21. 50	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21. 00
21. 55	Total program IOP OPPS payments (see instructions) Total program IOP Costs (see instructions)				21. 55
21. 60	Program IOP deductible and coinsurance (see instructions)				21. 60
22. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		53, 851	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			1, 014	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		354	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	s)		0	
26. 00	Net reimbursable amount (see instructions)			54, 510	1
26. 01	Sequestration adjustment (see instructions)			1, 090	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0 44 143	26. 02
27. 00	Interim payments Tentative settlement (for contractor use only)			46, 143 0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.4	02, 27, and 28)		7, 277	
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II.		0	30.00

	Financial Systems PARIS COMMUNI ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	N: 14-1320	Peri od:	wof Form CMS-2 Worksheet M-4	
		Component C	CCN: 14-3987	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:0	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00 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	8, 796, 285 0. 004138	8, 796, 28 0. 00862		8, 796, 285 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	36, 399	75, 84	12 0	0	3. 0
. 00	Injections/infusions and related medical supplies costs (from your records)	132, 124	71, 10	0	0	4.0
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)	168, 523 9, 192, 635	146, 94 9, 192, 63		0 9, 192, 635	5. 0 6. 0
. 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)	7, 523, 595 0. 018332	7, 523, 59 0. 01598		7, 523, 595 0. 000000	
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	137, 923 306, 446	120, 26 267, 20		0	1
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	707 433. 45 267	1, 47 181. 4 68	0.00	0 0. 00 0	12. 0
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0
4. 00		115, 731	123, 89	96 0	0	14. 0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		573, 655	15. 0
6. 00	Total Program cost of injections/infusions and their admin		(sum of		239, 627	16.0

		TY HOSPITAL	N 14 1220		eu of Form CMS-2	
JOMPU I	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	N: 14-1320	Peri od: From 01/01/2023	Worksheet M-4	
		Component C		To 12/31/2023	Date/Time Prep 5/23/2024 4:0	
		Title		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	447, 585 0. 005461	447, 58 0. 02012		447, 585 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	2, 444	9, 00	06 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	17, 193			0	4. 00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	19, 637	25, 37		0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	462, 575	462, 57	75 462, 575	462, 575	6.00
7. 00	Total overhead (from Wkst. M-2, line 19)	404, 139	404, 13			7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 042451	0. 05484			
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17, 156	22, 16		0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	36, 793	47, 53		0	
11.00	Total number of injections/infusions (from your records)	92 399, 92	33		0	
12. 00 13. 00	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	15	140. 2 12		0.00	12. 00 13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5, 999	16, 82	26 0	0	14.00
		'			COST OF	
					INJECTIONS /	
					INFUSIONS AND	
				1. 00	ADMI NI STRATI ON 2. 00	
15. 00	Total cost of injections/infusions and their administration	n costs (sum of	col umns 1.	1.00	84, 328	15. 00
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			2., 525	
16. 00	Total Program cost of injections/infusions and their admini	istration costs	(sum of	1	22, 825	1 16 00

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC		Peri od:	Worksheet M-4	
		Component C	CCN: 14-8596	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
		Title	XVIII	RHC III	Cost	•
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
. 00 !. 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	591, 358 0. 004516	591, 35 0. 03773		591, 358 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	2, 671	22, 31	4 0	0	3. (
. 00	Injections/infusions and related medical supplies costs (from your records)	5, 793	12, 50		0	4. (
6. 00 6. 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)	8, 464 611, 194	34, 81 611, 19		0 611, 194	5. (6. (
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)	274, 280 0. 013848	274, 28 0. 05696		274, 280 0. 000000	7. 8.
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration	3, 798 12, 262	15, 62 50, 44		0	
1. 00 2. 00 3. 00	costs (sum of lines 5 and 9) Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	31 395. 55 23	25 194. 7 12	0.00	0 0. 00 0	
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)	9, 098	24, 73	0		14.
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			62, 702	15.
6. 00	Total Program cost of injections/infusions and their admin	istration costs	(sum of		33, 831	16.

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC		Peri od:	Worksheet M-4	
		Component C		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
		Title	XVIII	RHC IV	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 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	2, 021, 075 0. 000000	2, 021, 07 0. 00041			
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	0	83	0	0	3.
1. 00	Injections/infusions and related medical supplies costs (from your records)	0	1, 30		0	
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)	0 2, 119, 040	2, 13 2, 119, 0 ⁴		2, 119, 040	5. (6. (
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)	2, 151, 929 0. 000000	2, 151, 92 0. 00100			
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	2, 16 4, 30		0	
1. 00 2. 00 3. 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	0 0.00 0	159. 4	27 0 14 0.00 16 0	0 0.00 0	1
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	2, 55	51 0	0	14.
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				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.		columns 1,		4, 305	15.
6. 00	Total Program cost of injections/infusions and their admin		(sum of		2, 551	16.

Health Financial Systems PARIS COMMUN	NITY HOSPITAL		In lie	eu of Form CMS-2	2552_10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	CN: 14-1320	Peri od:	Worksheet M-4	
	Component (CCN: 15-8573	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:0	
		XVIII	RHC VI	Cost	
	PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
	1.00	2.00	2. 01	2. 02	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 2.00 Ratio of injection/infusion staff time to total health care staff time	0. 000000	0. 00079	0.000000	0. 000000	
3.00 Injection/infusion health care staff cost (line 1 x line 2)	0		0	0	3. 00
4.00 Injections/infusions and related medical supplies costs (from your records)	0	96	0	0	4. 00
5.00 Direct cost of injections/infusions (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FQHC (from	0	96	0 0 0	0	
Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of injection/infusion direct cost to total direct	0. 000000	0. 00000	0 0	0.000000	
cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8)	0.000000	0.00000	0.00000	0.00000	
10.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	O	96	-	ō	
11.00 Total number of injections/infusions (from your records) 12.00 Cost per injection/infusion (line 10/line 11)	0.00	48. 2	0.00	0.00	11. 00 12. 00
13.00 Number of injection/infusion administered to Program beneficiaries	0	1	0	0	13. 00
13.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	O	48	0	0	14. 00
				COST OF INJECTIONS /	
				INFUSIONS AND ADMINISTRATION	
			1. 00	2. 00	
15.00 Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)	•		965	
16.00 Total Program cost of injections/infusions and their admir columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				483	16. 00

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL		In Lie	u of Form C	MS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider (Component		od: 01/01/2023 12/31/2023	Date/Time	Prepared:
					5/23/2024	4:01 pm

		Component CCN: 14-3987	10 12/31/2023	5/23/2024 4: 01	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			2, 563, 437	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		O	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	1 Togram to 11 ovi dei		08/24/2023	127, 392	3. (
. 02			007 247 2023	127, 372	3. (
. 02					3. (
. 04				0	3. (
. 05	Dravi dan ta Dragnam			0	3. (
F0	Provider to Program			0	2
50				0	3.
51					3.
52				0	3.
53				0	3.
54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			127, 392	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		2, 690, 829	4.
	27)				
00	TO BE COMPLETED BY CONTRACTOR		6		_
00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	Т		5.
	Program to Provider				
01				0	5.
. 02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		o	5.
00	Determined net settlement amount (balance due) based on the				6.
01	SETTLEMENT TO PROVIDER			335, 219	6.
02	SETTLEMENT TO PROGRAM			000, 217	6.
00	Total Medicare program liability (see instructions)			3, 026, 048	7.
. 50	Total modificate program trabitity (see thistractions)		Contractor	NPR Date	,.
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL		In Lie	eu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED		Provider CCN	I: 14-1320	Peri od:	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIA	RI ES	Component CC	CN: 14-3989	From 01/01/2023 To 12/31/2023	Date/Time Prepared:
					5/23/2024 4·01 nm

		Component Con. 14-3707	10 12/31/2023	5/23/2024 4: 0	
			RHC II	Cost	
			Pai	rt B	
			mm/dd/yyyy	Amount	
			1, 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			51, 503	1. (
. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. (
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3. (
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3.
	Provider to Program				
50			08/24/2023	866	3.
51				0	3.
52				0	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			-866	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		50, 637	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				_
01				0	5.
02				0	5.
03	Durani dana da Diranggan			0	5.
50	Provider to Program			1 0	-
50 51					5.
52					5. 5.
	Cultural (cum of lines 5 of 5 to minus cum of lines 5 50 5 oo)				
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)			ا	5. 6.
00	SETTLEMENT TO PROVIDER	e cost report. (1)		22 250	
)1				32, 350	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)		Contracts	82, 987	7.
			Contractor	NPR Date	
		0	Number 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor	U	1.00	2.00	8.
JU	Iname of Contractor	I	1	1	შ.

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED		Provider CCN: 14-1320	Peri od:	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIAR	I ES	Component CCN: 14-8596	From 01/01/2023 To 12/31/2023	Date/Time Prepared:
				5/23/2024 4:01 pm

		Component CCN: 14-8596	To 12/31/2023	Date/Time Prep 5/23/2024 4:01	
			RHC III	Cost	
·			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
	ayments paid to hospital-based RHC/FQH			99, 530	1
	s payable on individual bills, either for services rendered in the cost repo a zero			0	2
revision of the payment. If none	each retroactive lump sum adjustment interim rate for the cost reporting p e, write "NONE" or enter a zero. (1)				3
Program to Provi	der				
11			08/24/2023	21, 805	3
12				0	3
)3				0	3
4				0	3
5				0	3
Provider to Prog	gram				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
,	flines 3.01-3.49 minus sum of lines 3	•		21, 805	3
0 Total interim pa 27)	ayments (sum of lines 1, 2, and 3.99)	(transfer to Worksheet M-3, line		121, 335	4
TO BE COMPLETED	BY CONTRACTOR				
	each tentative settlement payment af f none, write "NONE" or enter a zero.		`		5
Program to Provi					
1	401			0	5
2				0	5
3				l ol	5
Provider to Prod	ıram				
0	,			0	5
1				0	5
2				0	5
	flines 5.01-5.49 minus sum oflines !	5. 50-5. 98)		0	5
	settlement amount (balance due) based				6
1 SETTLEMENT TO PI	ROVI DER			39, 346	6
2 SETTLEMENT TO PI	ROGRAM			0	6
O Total Medicare	orogram liability (see instructions)			160, 681	7
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1. 00	2.00	
				2.00	

Health Financial Systems	PARIS COMMUNITY H	IOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI			Peri od: From 01/01/2023	Worksheet M-5
	'	Component CCN: 14-8607		Date/Time Prepared: 5/23/2024 4:01 pm

		Component CCN: 14-8607	10 12/31/2023	5/23/2024 4: 01	
			RHC IV	Cost	
	<u> </u>		Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			423, 529	1. (
00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting problem 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 Togram to 1 Tovraci			0	3.
02				ő	3.
03					3.
04				o o	3.
05					3.
	Provider to Program			_	
50			08/24/2023	31, 998	3.
51				0	3.
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.49	98)		-31, 998	3.
OC	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		391, 531	4.
	27)				
	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	f		5.
	Program to Provider			_	_
01				0	5.
02				0	5.
03	Provider to Program			U	5.
50	Frovider to Frogram			0	5.
51					5.
52					5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)			5
00	Determined net settlement amount (balance due) based on the				6
)1	SETTLEMENT TO PROVIDER	opo (.)		49, 443	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			440, 974	7.
- 0	in the second se		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
			1.00	2.00	

Health Financial Systems	PARIS COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN:	14-1320	Peri od: From 01/01/2023	Worksheet M-5
SERVICES REINDERED TO PROGRAM BENEFICIAR		Component CCM	N: 14-8606		Date/Time Prepared: 5/23/2024 4:01 pm

		Component CCN: 14-8606	То	12/31/2023	Date/Time Prep 5/23/2024 4:01	
			<u> </u>	RHC V	Cost	
				Par		
				mm/dd/yyyy	Amount	
				1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC				46, 143	1. (
00	Interim payments payable on individual bills, either submit				0	2.
	the contractor for services rendered in the cost reporting	period. If none, write				
	"NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment amount					3.
	revision of the interim rate for the cost reporting period.	Also show date of each				
	payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider				0	2
01					0	3.
02					0	3.
03					0	3
04					0	3
)5					0	3
- 0	Provider to Program					0
50					0	3
51					0	3
52					0	3
53					0	3
54		20)			0	3
99	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	ter to Worksheet M-3, line			46, 143	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after des	k may i aw. Al aa ahaw data a	e			5
)()	leach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date of	'			Э
	Program to Provider			l		
01	Frogram to Frovider			I	0	5
)2					0	5
)3					0	5
,,	Provider to Program			l	0	J
50	11 ovi dei 16 11 ogi dili		Т	T	0	5
51					0	5
52					0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)			0	5
00	Determined net settlement amount (balance due) based on the				$\tilde{\ }$	6
)1	SETTLEMENT TO PROVIDER	3332 . opol c. (1)			7, 277	6
)2	SETTLEMENT TO PROGRAM				7,277	6
00	Total Medicare program liability (see instructions)				53, 420	7
	Total modical opiogram Trability (300 That actions)			Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		0		1. 00	2.00	
	Name of Contractor	<u> </u>		1.00	2.00	