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: 14-1309 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 8:55 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 8:55 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 CARLE EUREKA HOSPITAL (14-1309) 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 FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C SI GNATURE STATEMENT	
1	,		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			2
3	Signatory Title			3
4	Date			4

	·		Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-22, 083	-308, 962	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
4.00	SUBPROVI DER (OTHER)						4. 00
5.00	SWING BED - SNF	0	-203, 064	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC I	0		146, 629		0	10. 00
10. 01	RURAL HEALTH CLINIC II	0		-25, 189		0	10. 01
10. 02	RURAL HEALTH CLINIC (RHC) III	0		-36, 177		0	10. 02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	TOTAL	0	-225, 147	-223, 699	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems CARLE EUREKA HOSPITAL In Lieu of Form CMS-2552-10

	Financial Systems	CARLE EUREKA									2552-10
HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provid	der CC	CN: 14		Period: From 01/01/ To 12/31/	′2023 ′2023	Workshe Part I Date/Ti	me Pre	pared:
	1.00	2. 00		3. 00				4. 00	5/29/20	124 8:5	5 pm
1 00	Hospital and Hospital Health Care Co Street: 101 SOUTH MAJOR STREET										1.00
1. 00 2. 00	City: EUREKA	PO Box: State: IL	Zip Cod	e: 615	530	Count	y: WOODFORD				1. 00 2. 00
		Component Name	CCN	CB:	SA	Provi der	Date	Paymer	nt Syst		
			Number	Numl	ber	Type	Certified	V,	0, or	N) XIX	-
		1. 00	2.00	3. (00	4. 00	5. 00	6.00	7. 00		
2 00	Hospital and Hospital-Based Componen		444000	0.70	200		04 (04 (0004	l N			0.00
3. 00 4. 00	Hospi tal Subprovider - IPF	CARLE EUREKA HOSPITAL	141309	379	900	1	01/01/2001	N	0	0	3. 00 4. 00
5.00	Subprovider - IRF										5. 00
6.00	Subprovider - (Other)										6. 00
7. 00 8. 00	Swing Beds - SNF Swing Beds - NF	EUREKA SWING BED	14Z309	999	914		01/01/2001	N	0	N	7. 00 8. 00
9.00	Hospi tal -Based SNF										9.00
10.00	Hospi tal -Based NF										10.00
11.00	Hospi tal -Based OLTC Hospi tal -Based HHA										11. 00 12. 00
12. 00 13. 00	Separately Certified ASC										13. 00
14. 00	Hospi tal -Based Hospi ce										14. 00
15. 00	Hospital-Based Health Clinic - RHC	CARLE EUREKA FAMILY	148581	999	914		11/29/2017	N	0	N	15. 00
15. 01	Hospital-Based Health Clinic - RHC	CLINIC CARLE EL PASO FAMILY	148582	999	914		11/29/2017	N	0	N	15. 01
15. 02	 Hospital-Based Health Clinic - RHC	CLINIC CARLE ROANOKE	148620	999	914		12/29/2020	l N	0	N	15. 02
1/ 00	III										14 00
16. 00 17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16. 00 17. 00
	Hospital -Based (CORF) I							İ			17. 10
18.00	Renal Dialysis										18.00
19. 00	other						From:		To	<u> </u>	19. 00
							1.00		2. (00.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2	023	12/31/	2023	20.00
	1.5/2										
	Inpatient PPS Information					1. 00	2. 00		3. (00	
22. 00	Does this facility qualify and is it					N	N				22. 00
	disproporti onate share hospi tal adju			3							
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.									
22. 01	Did this hospital receive interim UC					N	N				22. 01
	this cost reporting period? Enter in for the portion of the cost reportin										
	1. Enter in column 2, "Y" for yes or		tion of th	ne							
	<pre>cost reporting period occurring on o instructions)</pre>	r after October 1. (see									
22. 02	Is this a newly merged hospital that	requires a final UCP to	be			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			nο							
	for the portion of the cost reportin			,							
22. 03	Did this hospital receive a geograph					N	N		N		22. 03
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin	g period prior to Octobe	er 1. Ente								
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft										
	Does this hospital contain at least			as							
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" fo	or							
22 04	yes or "N" for no. Did this hospital receive a geograph	ic reclassification from	n urhan to	1							22. 04
22.01	rural as a result of the revised OMB										22.01
	adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for			er							
	reporting period occurring on or aft	•									
	Does this hospital contain at least	100 but not more than 49	99 beds (a								
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter in column	13, "Y" 1	or							
23. 00	Which method is used to determine Me						O N				23. 00
	below? In column 1, enter 1 if date										
	if date of discharge. Is the method reporting period different from the			JUST							
	reporting period? In column 2, ente										

Health Financial Systems CARLE EUREKA HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1309 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 8: 55 pm XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 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 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

CARLE	FIIREKA HOSPITAI		Inlie	u of Form CMS_1	2552_10
		CN: 14-1309 Pe			
			12/31/2023		
		Unweighted		Ratio (col. 1/	
		Nonprovi der	Hospi tal	2))	
			2 00	2 00	
r FTE Residents in No	onprovider Settings				
uly 1, 2009 and befor	re June 30, 2010.				
ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	-primary care all nonprovider I non-primary care column 3 the ratio	0.00	0. 00	0. 000000	64. 00
Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
ŭ	, and the second	FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
1 00	2 00		4 00	5 00	
1.00	2.00	0.00			65. 00
		Unwei ahted	Unwei ahted	Ratio (col. 1/	
		FTEs	FTEs in	(col. 1 + col.	
		Nonprovi der	Hospi tal	2))	
			0.00	2.00	
Voar ETE Docidonts in	Nonprovidor Sottings				
	i Nonprovider Settings	3Lifective id	i cost reporti	ng perrous	
	y care resident	0.00	0. 00	0. 000000	66.00
Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
		' '	поѕрітаі	4))	
1. 00	2, 00		4.00	5. 00	
		0.00			67. 00
	r FTE Residents in Nouly 1, 2009 and befor yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in 1 + column 2)). (see Program Name 1.00 Year FTE Residents in 10 unweighted non-primar curring in all nonprumeighted non-primar al. Enter in column 3 column 2)). (see insections of the column 2). (see insections of the column 3). (see insections of the column 2)).	r FTE Residents in Nonprovider Settings uly 1, 2009 and before June 30, 2010. yes, or your facility trained residents ber of unweighted non-primary care tations occurring in all nonprovider number of unweighted non-primary care ur hospital. Enter in column 3 the ratio 1 + column 2)). (see instructions) Program Name Program Code 1.00 2.00 Year FTE Residents in Nonprovider Settings 10 unweighted non-primary care resident ccurring in all nonprovider settings. unweighted non-primary care resident al. Enter in column 3 the ratio of column 2)). (see instructions) Program Name Program Code	EX IDENTIFICATION DATA Provider CCN: 14-1309 PF FT T Unweighted FTEs Nonprovider Site 1.00 r FTE Residents in Nonprovider SettingsThis base year uly 1, 2009 and before June 30, 2010. yes, or your facility trained residents ber of unweighted non-primary care tations occurring in all nonprovider number of unweighted non-primary care ur hospital. Enter in column 3 the ratio 1 + column 2)). (see instructions) Program Name Program Code Unweighted FTEs Nonprovider Site 1.00 2.00 3.00 0.00 Year FTE Residents in Nonprovider SettingsEffective for 10 Unweighted non-primary care resident 0.00	EX I DENTIFICATION DATA Provider CCN: 14-1309 Period: From 01/01/2023 To 12/31/2023 Unweighted FTES Unweighted FTES in Hospital	Provider CCN: 14-1309

118. 00

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	CARLE EUREKA	HOSPI TAL		In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC		Period: From 01/01/2023	Worksheet S Part I	5-2
			-	Го 12/31/2023	Date/Time P 5/29/2024 8	
			Premi ums	Losses	Insurance	
			1.00	2.00	2.00	
118.01 List amounts of mal practice premi	ums and paid Losses:		1.00	2. 00 4 C	3.00	343 118. 01
	,					
118.02 Are mal practice premiums and paid	losses reported in a cost of	center other t	han the	1. 00 N	2. 00	118. 02
Administrative and General? If you and amounts contained therein.	es, submit supporting schedu	ule listing co	ost centers			
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualif	es for the Outpatient Hold	Harmless prov	vision in ACA	N	N	119. 00 120. 00
§3121 and applicable amendments?	(see instructions) Enter in	col umn 1, "Y"	for yes or			
"N" for no. Is this a rural hospi Hold Harmless provision in ACA §3						
Enter in column 2, "Y" for yes or	"N" for no.		•			
121.00 Did this facility incur and repor- patients? Enter "Y" for yes or "N		ntable devices	s charged to	Y		121. 00
122.00 Does the cost report contain heal	thcare related taxes as defi			N		122. 00
Act?Enter "Y" for yes or "N" for the Worksheet A line number where		is "Y", enter	r in column 2			
123.00 Did the facility and/or its subpro	oviders (if applicable) purc			Y	Y	123. 00
services, e.g., legal, accounting management/consulting services, f						
for yes or "N" for no.	· ·					
If column 1 is "Y", were the major professional services expenses, for						
located in a CBSA outside of the i						
"N" for no. Certified Transplant Center Infor	mation					
125.00 Does this facility operate a Medi	care-certified transplant ce		Y" for yes	N		125. 00
and "N" for no. If yes, enter cer 126.00 If this is a Medicare-certified k			fication date	,		126. 00
in column 1 and termination date,			:: . :			107.00
127.00 f this is a Medicare-certified he in column 1 and termination date,	if applicable, in column 2.					127. 00
128.00 If this is a Medicare-certified I			ication date			128. 00
in column 1 and termination date, 129.00 If this is a Medicare-certified I			cation date			129. 00
in column 1 and termination date, 130.00 f this is a Medicare-certified pa			rti fi cati on			130. 00
date in column 1 and termination			tilication			130.00
131.00 If this is a Medicare-certified in date in column 1 and termination			certi fi cati on			131. 00
132.00 If this is a Medicare-certified is	slet transplant program, ent	ter the certif	cation date			132. 00
in column 1 and termination date, 133.00 Removed and reserved	if applicable, in column 2.					133. 00
134.00 If this is a hospital-based organ			ne OPO number			134. 00
in column 1 and termination date, All Providers	if applicable, in column 2.					
140.00 Are there any related organization				Y	14H077	140. 00
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the						
1.00	2. 00			3. 00	'	
If this facility is part of a cha home office and enter the home of				ame and address	of the	
141.00 Name: CARLE HEALTH SYSTEM	Contractor's Name: NGS			r's Number: 0610)1	141. 00
142.00 Street: 611 W PARK STREET 143.00 City: URBANA	PO Box: State: IL		Zip Code:	6182	20	142. 00 143. 00
	1-1-1-1		<u> </u>			
144.00 Are provider based physicians' co	sts included in Worksheet AG	?			1. 00 Y	144. 00
zacea prijererano	sto moradou m nomeneo m					111100
145.00 If costs for renal services are c	aimed on Wkst A line 74	are the costs	for	1. 00	2. 00	145. 00
inpatient services only? Enter "Y	' for yes or "N" for no in o	column 1. If c	column 1 is			1.43.00
no, does the dialysis facility in period? Enter "Y" for yes or "N"	clude Medicare utilization f	for this cost	reporting			
146.00 Has the cost allocation methodolog	gy changed from the previous			N		146. 00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/		5-2, chapter 4	10, §4020) If			
13 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	55557			1	1	1

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	CARLE EUREK	Provider CC	`N · 14_13∩0	Peri		u of Form CMS Worksheet S-	
NOSPITAL AND HOSPITAL HEALTH CARE COMPLE	A IDENTIFICATION DATA	Frovider CC	N. 14-1303		01/01/2023 12/31/2023	Part I Date/Time Pr 5/29/2024 8:	epared
							Jo pili
 47.00 Was there a change in the statisti	cal basis? Entor "V" for	vos or "N" for	no			1. 00 N	147. 0
148.00 Was there a change in the order of						N N	148. 0
149.00 Was there a change to the simplifi				for no		N N	149. 0
177. 00 mas there a change to the shipiri	ed cost finding method. E	Part A	Part		Title V	Title XIX	117.0
		1, 00	2.00		3.00	4.00	
Does this facility contain a prov	der that qualifies for ar						
or charges? Enter "Y" for yes or							
55. 00 Hospi tal	•	Y	Y		N	N	155. (
56.00 Subprovider - IPF		N	N		N	N	156. 0
57.00 Subprovi der - IRF		N	N		N	N	157. (
58. 00 SUBPROVI DER							158. (
59. 00 SNF		N	N		N	N	159. (
60.00 HOME HEALTH AGENCY		N	N N		N	N	160. (
61. 00 CMHC			N N		N	N	161. (
61. 10 CORF			N		N	N	161.
						1.00	
Multicampus							
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has or	e or more campu	uses in di	fferent	CBSAs?	N	165. (
	Name	County	State	Zip Coc	le CBSA	FTE/Campus	
	0	1. 00	2.00	3.00	4. 00	5. 00	
66.00 If line 165 is yes, for each						O. C	00 166. (
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI					t		
67.00 s this provider a meaningful use	under §1886(n)? Enter "	Y" for yes or "	'N" for no			N	167.
68.00 If this provider is a CAH (line 10			e 167 is "	Y"), ent	er the		168. (
reasonable cost incurred for the I	`	,					
68.01 If this provider is a CAH and is i					ardshi p		168. (
exception under §413.70(a)(6)(ii)							
69.00 If this provider is a meaningful transition factor. (see instruction		IIS NOT A CAH ((line 105	IS "N"),	enter the	0.0	00169. (
transition factor. (see instruction	015)				Begi nni ng	Endi ng	
					1. 00	2.00	_
70.00 Enter in columns 1 and 2 the EHR I	peginning date and ending	date for the re	eporting		1. 00	2.00	170. (
period respectively (mm/dd/yyyy)							
					1. 00	2.00	+
71.00 If line 167 is "Y", does this prov	vider have any days for in	di vi dual s enrol	led in				0171.0
section 1876 Medicare cost plans ("Y" for yes and "N" for no in colu	reported on Wkst. S-3, Pt.	I, line 2, col	. 6? Ente				

Health Financial Systems CARLE EUREKA HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1309 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 8:55 pm Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7 00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 04/09/2024 04/09/2024 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for 17 00 N N totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems CARLE EUREK.	A HOSPITAL		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 14-1309	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/29/2024 8	repared:
		Descri	pti on	Y/N	Y/N	,, oo p
	to and	()	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
	report data for other; bescribe the other adjustments.	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 (EXCE	PT CHILDRENS H	OSPLTALS)		1. 00	
	Capital Related Cost	IT OIII EDILEIGO II	001117120)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	Plf yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	ges, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see	N	31. 00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	uctions.	-		N	32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, see instructions.	olied pertainin	g to competi	tive bidding? If		33. 00
24.00	Provider-Based Physicians Were services furnished at the provider facility under an a	annangamant wit	b providor k	acad physicians?	Υ	24 00
34. 00	If yes, see instructions.	· ·		. ,	ř	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		ts with the	provi der-based	N	35. 00
				Y/N	Date	
	Homo Offi on Costs			1.00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			F N		38. 00
39. 00	1 1 3 1			s, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
	T	1.	00	2.	00	
41. 00		KYLE		LEE		41. 00
40.00	held by the cost report preparer in columns 1, 2, and 3, respectively.	CADLE LIENTIL C	VCTEM			42.00
42. 00	Enter the employer/company name of the cost report preparer.	CARLE HEALTH S	YSIEM			42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953		KYLE. LEE2@CARLI	E. COM	43. 00

Heal th	Financial Systems CARLE EU	JREK <i>A</i>	A HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1309	eriod: rom 01/01/2023 o 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/29/2024 8:5	pared:
			3.00			
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3 respectively.		DIRECTOR OF FINANCE			41. 00
42. 00	Enter the employer/company name of the cost report preparer.					42.00
43. 00	Enter the telephone number and email address of the cos report preparer in columns 1 and 2, respectively.	t				43. 00

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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-1309

				'	0 12/31/2023	5/29/2024 8:5	
						I/P Days / 0/P	J ()
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	·	Li ne No.		Avai I abl e			
		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	17, 068. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)						2. 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider						3. 00
4. 00	HMO IRF Subprovider						4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation		25	9, 125	17, 068. 00		7. 00
7.00	beds) (see instructions)		25	7, 123	17,000.00	o o	7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00	o	0	0.00	o	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	17, 068. 00	0	14.00
15.00	CAH visits					0	15.00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	41. 00		0		0	17. 00
18. 00	SUBPROVI DER	42. 00	0	0		0	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 24. 10	HOSPICE	30. 00					24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01				Ö	26. 01
26. 02	RURAL HEALTH CLINIC (RHC)	88. 02				l o	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				l o	26. 25
27. 00	Total (sum of lines 14-26)		25			_	27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
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

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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

					0 12/31/2023	5/29/2024 8:5	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	5 piii
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7, 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	337	0	743			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)	149	31				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0	750			4. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF	560	193 122	753 122			5. 00 6. 00
7. 00	Hospital Adults & Peds. Swing Bed NF	897	315				7.00
8. 00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT	897	315	1, 618			8.00
9. 00	CORONARY CARE UNIT						9.00
10. 00	BURN INTENSIVE CARE UNIT	0	0	0	1		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)	897	315	1, 618	0.00	94. 12	
15. 00	CAH visits	0	0.0	.,	0.00	/	15. 00
15. 10	REH hours and visits	0	o	C			15. 10
16. 00	SUBPROVI DER - I PF			_			16. 00
17. 00	SUBPROVIDER - IRF	0	o	C	0.00	0.00	1
18. 00	SUBPROVI DER		o	C	0.00	l e	1
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)			C)		24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0	0	C	0.00	0.00	25. 10
26. 00	RURAL HEALTH CLINIC	4, 470	0	15, 502			•
26. 01	RURAL HEALTH CLINIC II	1, 811	0	5, 445		6. 24	
26. 02	RURAL HEALTH CLINIC (RHC)	149	0	850		l .	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		l .	•
27. 00	Total (sum of lines 14-26)				0.00	124. 25	27. 00
28. 00	Observation Bed Days		0	108			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30. 00	Employee discount days (see instruction)			C			30. 00
31. 00	Employee discount days - IRF			C			31.00
32. 00	Labor & delivery days (see instructions)	0	0	C			32.00
32. 01	Total ancillary labor & delivery room			C	'		32. 01
22 00	outpatient days (see instructions)	0					22 00
33. 00 33. 01	LTCH non-covered days	0					33. 00 33. 01
	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	0	0	C			34.00
34.00	Transporary Expansion Covid-19 Pric Acute Care	ı o	٠Į	U	'1	I	J 34. UU

Provider CCN: 14-1309

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				10) 12/31/2023	5/29/2024 8:5	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	97	2	185	1.00
2. 00	HMO and other (see instructions)			42	8		2.00
3. 00	HMO IPF Subprovider			72	0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				٩		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						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)	0. 00	0	97	2	185	14. 00
15. 00	CAH visits	0.00	0	77	2	103	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	0	o	0	17. 00
18. 00	SUBPROVI DER	0.00	0		0	0	18.00
19. 00	SKILLED NURSING FACILITY	0.00	0		ĭ	O	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	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC (RHC)	0.00					26. 02
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	0.00					28. 00
29. 00	Ambul ance Tri ps						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Fristraction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room				ŀ		32. 01
52.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansi on COVID-19 PHE Acute Care						34.00

103PT I	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1309	Peri od:	Worksheet	S-8	
				CCN: 14-8581	From 01/01/202 To 12/31/202	3	Prep	
					RHC I	Cos		, рііі
	Clinic Address and Identification				1	1.00	-	
. 00	Street				105 S MAJOR S	T T		1.
	1		Ci	ty	State	ZIP Code		
				00	2. 00	3. 00		
. 00	City, State, ZIP Code, County		EUREKA			L 61530		2.
						1.00		
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban			0	3.
	-				nt Award	Date		
	Course of Fodoral Funda				1. 00	2. 00		
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		1				4.
. 00	Migrant Health Center (Section 329(d), PHS Ad						l	5.
. 00	Health Services for the Homeless (Section 340							6.
. 00	Appalachian Regional Commission							7.
. 00	Look-Alikes OTHER (SPECIFY)							8.
. 00	OTHER (SPECIFY)							9.
					1. 00	2.00		
0. 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.)	r otner operati	on(s) and the	operating				
	Thouse of y							
		Sur	iday	I IV	Monday	Tuesday		
		from	to	from	to	from		
	Facility hours of propertions (1)							
1 00	Facility hours of operations (1)	from	to	from 3.00	to 4.00	from 5.00		11
1. 00	Facility hours of operations (1)	from	to	from	to	from		11.
1. 00	CLINIC	from 1.00	to 2.00	from 3.00	to 4.00	from 5.00		11.
2. 00	Have you received an approval for an exception	from 1.00 on to the produ	to 2.00	from 3.00 08:30	17: 30 1. 00 N	from 5.00		12.
2. 00	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 standal 00-04, chapter	from 3.00 08:30	to 4. 00	from 5.00	0	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 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	from 3.00 08:30 ord? 9, section in 2 the	17: 30 1. 00 N	from 5.00	0	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 columber of providers included in this report. In numbers below.	from 1.00 on to the product of in CMS Pub. Jumn 1. If yes, List the names	to 2.00 activity standa 100-04, chapter enter in colum s of all provice	from 3.00 08:30 ord? 9, section 1 2 the 1 lers and	17: 30 1. 00 N	from 5.00	0	12.
2. 00 3. 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 reportion.	from 1.00 on to the product of in CMS Pub. fumn 1. If yes, List the names	to 2.00 activity standa 100-04, chapter enter in colum s of all provic	from 3.00 08:30 ord? 9, section 1 2 the lers and 2s (as define	17: 30 1. 00 N	from 5.00		12. 13.
2. 00 3. 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 100-04, chapter enter in colum s of all provic	from 3.00 08:30 ord? 9, section 12 the elers and 2s (as define for no. If	17: 30 1. 00 N	from 5.00		11. 12. 13.
1. 00 2. 00 3. 00 3. 01	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 reportion.	from 1.00 on to the product of the control of the product of the	to 2.00 activity standa 100-04, chapter enter in colum s of all provic consolidated RHC For yes or "N" bings and compl	from 3.00 08:30 ord? 9, section in 2 the ers and es (as define for no. If ete a	17: 30 1. 00 N N N	from 5.00		12. 13.
2. 00 3. 00	Have you received an approval for an exception and the state of the st	from 1.00 on to the product of the	to 2.00 activity standa 100-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 ord? 9, section 1 2 the 1 lers and 0 s (as define 1 for no. If 1 ete a 1 RHC grouping	17: 30 1. 00 N N N	from 5.00		12. 13.
2. 00 3. 00	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of the	to 2.00 activity standa 100-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 08:30 ord? 9, section n 2 the lers and s (as define for no. If ete a RHC grouping ing or	17: 30 1. 00 N N N N S	from 5.00 08:30 2.00		12. 13.
2. 00 3. 00	Have you received an approval for an exception and the state of the st	from 1.00 on to the product of the	to 2.00 activity standa 100-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 08:30 rd? 9, section 12 the lers and 2s (as define for no. If ete a RHC grouping ing or	to 4.00 17:30 1.00 N N	608: 30 2. 00 CCN		12. 13.
2. 00 3. 00 3. 01	Have you received an approval for an exception and the state of the st	from 1.00 on to the product of the	to 2.00 activity standa 100-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" bings and compl Consolidated cs in the group	from 3.00 08:30 08:30 rd? 9, section 12 the lers and 2s (as define for no. If ete a RHC grouping ing or	17: 30 1. 00 N N N N S	from 5.00 08:30 2.00		12. 13.
2. 00 3. 00 3. 01	Have you received an approval for an exception of the state of the sta	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 100-04, chapter enter in colum s of all provic consolidated RHC For yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 17:30 1.00 N N N iden name 1.00 XIX	608: 30	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	from 1.00 on to the product of the	to 2.00 activity standa 100-04, chapter enter in colum s of all provic consolidated RHC for yes or "N" bings and compl Consolidated cs in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and es (as define for no. If ete a RHC grouping ing or Prov	to 4.00 17:30 1.00 N N N d N S ider name 1.00	60	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	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 grouping. Onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 100-04, chapter enter in colum s of all provic consolidated RHC For yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 17:30 1.00 N N N iden name 1.00 XIX	608: 30	0	12. 13.
2. 00 3. 00 3. 01	Have you received an approval for an exception of the state of the sta	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 grouping. Onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 100-04, chapter enter in colum s of all provic consolidated RHC For yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 17:30 1.00 N N N iden name 1.00 XIX	608: 30	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	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 grouping. Onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 100-04, chapter enter in colum s of all provic consolidated RHC For yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 17:30 1.00 N N N iden name 1.00 XIX	608: 30	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	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 grouping. Onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 100-04, chapter enter in colum s of all provic consolidated RHC For yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 17:30 1.00 N N N iden name 1.00 XIX	608: 30	0	12. 13.
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	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 grouping. Onsolidated RHC Cs in the group Y/N 1.00	to 2.00 activity standa 100-04, chapter enter in colum s of all provic consolidated RHC For yes or "N" bings and compl Consolidated s in the group bing.	from 3.00 08:30 08:30 rd? 9, section in 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	to 4.00 17:30 1.00 N N N iden name 1.00 XIX	608: 30	0	12. 13.

Health Financial Systems	CARLE EUREK	A HOSPITAL		In Lieu of Form CMS-2552		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-1309	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8581	From 01/01/2023 To 12/31/2023		
				RHC I	Cost	
		Cou	unty			
		4.	00			
2.00 City, State, ZIP Code, County		WOODFORD				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: 30	08: 30	17: 30	08: 30	17: 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: 30	17: 30	08: 30	14: 30		11. 00

	Financial Systems	CARLE EUREK	A HOSPITAL		In Li	eu of Form CMS	S-255	52-10
HOSPI ⁻	FAL-BASED RHC/FQHC STATISTICAL DATA		Provider Component (CN: 14-1309 CCN: 14-8582	Period: From 01/01/2023 To 12/31/2023		repar	
					RHC II	Cost		
					1	. 00	-	
	Clinic Address and Identification					. 00		
1. 00	Street		C:	1	385 S ORANGE S		1	1. 00
				ty 00	State 2.00	ZIP Code 3.00		
2. 00	City, State, ZIP Code, County		EL PASO			61738	1	2. 00
						1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	ıl or "II" for u	rhan		1.00	0 ;	3. 00
3.00	THOSE THE BASES FRIENDS ONET. BEST GREAT OF LITTLE	zi k roi rure	11 01 0 101 0		nt Award	Date	<u> </u>	3. 00
					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	0.00		
10. 00	Does this facility operate as other than a ho	nsnital-hased R	PHC or FOHC2 En	ter "Y" for	1. 00 N	2. 00	0 10	0. 00
.0.00	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 c	ther operation	s in column				0.00
			day	N	Monday	Tuesday		
		from 1.00	2. 00	from 3.00	4. 00	from 5.00		
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00		
11.00	CLINIC			08: 00	17: 00	08: 00	1	1. 00
					1.00	2.00	-	
12. 00	Have you received an approval for an exception	on to the produ	ıctivity standa	rd?	1.00 N	2.00	1:	2. 00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section in 2 the	N			3. 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	3. 01
				Prov	ider name	CCN		
14.00	DUC/FOLIC name CON				1. 00	2. 00	-	4 00
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	_	4. 00
		1. 00	2.00	3. 00	4. 00	5. 00		
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						11!	5. 00

Health Financial Systems	CARLE EUREK	A HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1309	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8582	From 01/01/2023 To 12/31/2023		epared: 5 pm
				RHC II	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		WOODFORD				2. 00
	Tuesday	Wedn	Wednesday		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	17: 00	08: 00	17: 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	07: 30	17: 00				11. 00

10SPI	n Financial Systems FAL-BASED RHC/FQHC STATISTICAL DATA	CARLE EUREK		CN: 14-1309	In Li Peri od:	Worksheet :		
				CCN: 14-8620	From 01/01/202 To 12/31/202	3 3 Date/Time	Prep	
					RHC III	5/29/2024 Cos		5 pm
	Clinic Address and Identification					1.00		
. 00	Street				415 WEST FRON	T STREET		1.
			Ci	ty	State	ZIP Code		
				00	2. 00	3. 00		
00	City, State, ZIP Code, County		ROANOKE		I	L 61561		2.
						1. 00		
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for ι				0	3.
					nt Award	Date		
					1. 00	2. 00		
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Ac+)		T		T		4.
. 00	Migrant Health Center (Section 329(d), PHS Ac						l	5.
00	Health Services for the Homeless (Section 340)							6.
00	Appal achi an Regi onal Commissi on							7.
00	Look-Alikes							8.
00	OTHER (SPECIFY)							9.
					1.00	2.00		
0. 00	Does this facility operate as other than a ho	osnital based F	PHC or FOHC2 Fr	ter "V" for	1. 00 N	2.00		10.
). UU	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of	ate number of d	other operation	ns in column				10.
	hours.)	C	. d		4	Torreden		
		from	nday to	from	Monday to	Tuesday from		
		1.00	2.00	3.00	4. 00	5. 00		
	Facility hours of operations (1)					·		
1. 00	CLINIC			07: 00	05: 00	07: 00		11.
					1. 00	2.00	_	
2. 00	Have you received an approval for an exception	on to the produ	ictivity standa	ard?	1.00	2.00		12.
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N		0	13.
	numbers below.		·					
3. 01	If line 13, column 1, is "Y", are you reporti 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 co comprised exclusively of new consolidated RHG)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC	for yes or "N" pings and compl Consolidated Cs in the group	for no. If ete a RHC grouping			0	13.
					ider name	CCN		
	Town with the second				1. 00	2. 00		
4. 00	RHC/FQHC name, CCN	V/ /NI		20/11/	VIV	T		14.
		Y/N 1,00	V 2 00	XVIII	XIX	Total Visit	ts	
5. 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	1.00	2.00	3.00	4.00	5. 00		15.

Health Financial Systems	CARLE EUREK	A HOSPITAL		In Lie	2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der CC	CN: 14-1309	Peri od:	Worksheet S-8	-
		Component (CCN: 14-8620	From 01/01/2023 To 12/31/2023		
				RHC III	Cost	
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		WOODFORD				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	05: 00			07: 00	05: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)				<u> </u>		
11. 00 CLINIC	07: 00	05: 00				11. 00

HOSPI T	Financial Systems CARLE EUREKA HOS AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCI		Peri od:	u of Form CMS-2 Worksheet S-10	
				From 01/01/2023	Parts I & II	
				To 12/31/2023	Date/Time Prep 5/29/2024 8:5	
					1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1. 00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					İ
. 00	Cost to charge ratio (see instructions)				0. 589805	1.0
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid				1, 992, 302	2. 0
. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplement			i d?	Υ	4.0
. 00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			0	5.0
. 00 '. 00	Medicaid charges				5, 994, 262 3, 535, 446	6. 0 7. 0
. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (saa instruc	tions)		1, 543, 144	
. 00	Children's Health Insurance Program (CHIP) (see instructions fo				1, 343, 144	0.0
. 00	Net revenue from stand-alone CHIP	. 04011 11110	7		0	9.0
0. 00	Stand-alone CHIP charges				0	10.0
1. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.0
2. 00	Difference between net revenue and costs for stand-alone CHIP (0	12.0
	Other state or local government indigent care program (see inst					
3. 00	Net revenue from state or local indigent care program (Not incl				0	13.0
4. 00	Charges for patients covered under state or local indigent care	program (N	lot included	in lines 6 or	0	14.0
F 00	10)	`			0	 15. C
5. 00 6. 00	State or local indigent care program cost (line 1 times line 14 Difference between net revenue and costs for state or local ind		program (soc	instructions)	0	
0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHI					10.0
	instructions for each line)	i una state	7100di Tildi g	ent care program	13 (300	
7. 00	Private grants, donations, or endowment income restricted to fu	nding chari	ty care		0	17.0
8. 00	Government grants, appropriations or transfers for support of h	ospital ope	rati ons		0	18. C
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent c	are programs	(sum of lines	1, 543, 144	19. C
	8, 12 and 16)		Hai noused	Lacusod	Total (agl 1	
			Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2)	
			1.00	2. 00	3.00	
	Uncompensated care cost (see instructions for each line)		00	2.00	5. 50	
0. 00	Charity care charges and uninsured discounts (see instructions)		122, 69	107, 505	230, 204	20. C
1. 00	Cost of patients approved for charity care and uninsured discou	nts (see	72, 36	82, 927	155, 295	21.0
	instructions)					
2. 00	Payments received from patients for amounts previously written	off as		0 0	0	22.0
3. 00	charity care Cost of charity care (see instructions)		72, 36	82, 927	155, 295	22 0
3.00	cost of charity care (see Histructions)		72, 30	02, 727	155, 245	23.0
					1. 00	
4. 00	Does the amount on line 20 col. 2, include charges for patient imposed on patients covered by Medicaid or other indigent care		la length of	stay limit	N	24. 0
5. 00	If line 24 is yes, enter the charges for patient days beyond th		care program	's length of	0	25. 0
E 01	Stay limit Charges for incured nationts' liability (see instructions)				EO 010) a.e. o
5. 01 6. 00	Charges for insured patients' liability (see instructions)				59, 918	
	Bad debt amount (see instructions)				834, 410	ا ∠o. (
	Medicare reimbursable had debts (see instructions)				12 271	27 r
7. 00 7. 01	Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)				43, 374 66, 730	

767, 680 28. 00

476, 138 29. 00 631, 433 30. 00 2, 174, 577 31. 00

27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

OSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN: 14	4-1309	Peri od: From 01/01/2023 To 12/31/2023		pared
					1. 00	
	PART II - HOSPITAL DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
. 00	Cost to charge ratio (see instructions)					1.
	Medicaid (see instructions for each line)				1	
. 00	Net revenue from Medicaid					2.
. 00	Did you receive DSH or supplemental payments from Medicaid?					3.
00	If line 3 is yes, does line 2 include all DSH and/or suppleme	1 3	om Medica	ai d?		4.
00	If line 4 is no, then enter DSH and/or supplemental payments	rrom Medicald				5.
00	Medicaid charges Medicaid cost (line 1 times line 6)					6.
00	Difference between net revenue and costs for Medicaid program	m (coo instruction	nc)			8.
00	Children's Health Insurance Program (CHIP) (see instructions		113)			0.
00	Net revenue from stand-alone CHIP	Tor each time)				9.
	Stand-alone CHIP charges					10.
	Stand-alone CHIP cost (line 1 times line 10)					111.
	Difference between net revenue and costs for stand-alone CHIF	P (see instruction	ns)			12
	Other state or local government indigent care program (see in)		1
3. 00	Net revenue from state or local indigent care program (Not in					13.
4. 00	Charges for patients covered under state or local indigent ca	are program (Not i	i ncl uded	in lines 6 or		14.
	10)					
5. 00	State or local indigent care program cost (line 1 times line	14)				15.
6. 00	Difference between net revenue and costs for state or local i					16.
	Grants, donations and total unreimbursed cost for Medicaid, (instructions for each line)	CHIP and state/loc	cal indiç	gent care progra	ms (see	
7. 00	Private grants, donations, or endowment income restricted to	funding charity o	care			17.
8. 00	Government grants, appropriations or transfers for support of					18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc	cal indigent care	programs	s (sum of lines		19.
	8, 12 and 16)	Un	ni nsured	Laguage	Total (col. 1	
			ati ents	I nsured pati ents	+ col . 2)	
		ρ	1. 00	2. 00	3.00	
	Uncompensated care cost (see instructions for each line)		1.00	2.00	3.00	
0. 00	Charity care charges and uninsured discounts (see instruction	ns)				20.
1. 00	Cost of patients approved for charity care and uninsured disc					21.
	instructions)	(11)				
2. 00	Payments received from patients for amounts previously writte charity care	en off as				22.
3. 00	Cost of charity care (see instructions)					23.
					1.00	
00	Does the amount on line 20 col. 2, include charges for patier	nt days bayand a l	Longth of	F ctov limit	1. 00	24.
1. 00	imposed on patients covered by Medicaid or other indigent car	, ,	rength of	stay IIIII t		24.
5. 00	If line 24 is yes, enter the charges for patient days beyond		a nrogran	m's Lanath of		25.
,. 00	pri rine 2+ is yes, enter the charges for patrent days beyond	the thurgent call	c prograi	ıı ə rengtii üi	1	1 40

25.01

26.00

27. 00

27. 01 28.00

29.00

30.00 31.00

25.01

stay limit

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

Charges for insured patients' liability (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

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

Court Counter Research Florida Counter Research Florida Counter Research Florida Counter Research Florida Counter Research Florida Counter Research Florida Counter Research Florida Counter Research Florida Counter Research Florida Counter Research Florida	Heal th	Financial Systems	CARLE EUREKA	HOSPI TAL		In Lie	u of Form CMS-	2552-10
Dest Centure Description	RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co			Worksheet A	
Salaries							Date/Time Pre	pared:
COLUMB C							5/29/2024 8:5	5 pm
ERINGAL SERVICE COST CENTERS 1.00 0.0000 CAP FEEL COST CENTERS 0.00000 CAP FEEL COST CENTERS 0.00000 CAP FEEL COST CENTERS 0.000000 CAP FEEL COST CENTERS 0.00000 CAP FEEL COST CENTERS 1.000000 CAP FEEL COST CENTERS 1.0000000 CAP FEEL COST CENTERS 1.00000000 CAP FEEL COST CENTERS 1.00000000000000000000000000000000000		Cost Center Description	Sal ari es	Other				
					+ (01. 2)	ons (see A-o)		
CERNINAL SEMPLICE COST CEMTERS 1.00 0.								
0.000 DOTION CAP MEL COSTS-BILIG & 1 LYA 1.00 DOTION CAP MEL COSTS AND E POLICY P. 1.00 DOTION CAP MEL COSTS AND E P. 1.00 DOTION CAP MEL COST			1. 00	2. 00	3. 00	4. 00	5. 00	
1.01 0.010 NW 2016 BILLINING & TIXT ADDITION 0 0 0 0 0 0 0 0 0	1 00			0	ı	0 220 504	220 E04	1 00
2.00 DOZIGO CAP RIT COSTS WHILE FOULP 0 0 0 0 0 0 0 0 0				0				1
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10.00 10000 DICTARY 187, 200 127, 492 314, 692 -30, 566 284, 118 10.00 13.00 13300 UNISAN CANDINISTRATION 328, 922 121, 935 450, 895 -13 38, 893 14.00 1			0	0		0 0		
13.00 01300 MURSING ADMINISTRATION 328, 922 121, 955 450, 857 -2, 660 447, 107 13.00 14.00 14.00 01400 01500 PHABMACY 265, 405 1, 225, 239 1, 490, 644 -423, 678 1, 066, 966 15.00 17.00 01500 PHABMACY 265, 405 1, 225, 239 1, 490, 644 -423, 678 1, 066, 966 15.00 17.00 01700 SIGLAL SPRINGE STRITTSTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
14. 00 01400 PARMANCY 14. 009 1, 225. 203 1, 490. 644 -423, 678 1, 606, 66 15. 00 15. 00 1500 PARMANCY 265, 405 0 0 0 0 0 0 0 0 0								•
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INPATI ENT ROUTINE SERVICE COST CENTERS			0	0		0	0	
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33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 41.00	20 00		1 202 260	600 757	2 002 11	7 172 767	1 920 250	20.00
11.00 04100 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0			1, 303, 300	099, 757	2,003,11	0 -172,707		1
ANCILLARY SERVICE COST CENTERS			o	0		0 0	_	•
50.00	42.00		0	0		0 0	0	42. 00
53.00 05300 ANSTHESIOLOCY 301,759 67,355 459,114 -20,630 438,484 52,00 57,00 05700 CT SCAN 0 0 0 0 0 0 0 0 57,00 05700 CT SCAN 0 0 0 0 0 0 0 0 0				700.050	1 400 70		05/ 0/0	
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57.00 05700 05700 07 07 07 07								1
99.00 OSPOO CARDINAC CATHETERI ZATI ON 0 0 0 0 0 59.00			0	0	1,277,00	0 0		
0.00 0.0000 0.0000 LABORATORY 705, 258 994, 346 1, 699, 604 -15, 648 1, 683, 956 60, 00 60, 01 0.000			0	0		0	0	
60.01 0.0001 0.000 0.0			0	0	4 (00 (0	0 0	0	
64.00 06400 INTRAVENDUS THERAPY 0 0 0 0 0 64.00 65.00 06500 RESPIRATORY HERAPY 87,185 70,288 157,473 -11,116 146,357 65.00 66.00 06600 PHYSI CAL THERAPY 497,616 145,934 643,550 -27,034 616,516 66.00 67.00 06700 0CCUPATI ONAL THERAPY 123,256 38,093 161,349 0 161,349 67.00 68.00 06800 SPEECH PATHOLOGY 18,600 31,413 50,013 -26,688 23,325 68.00 69.00 06900 ELECTROCARDI OLOGY 229,580 55,661 285,241 -12,369 272,872 69.00 69.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 169,033 169,033 72,00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 169,033 169,033 72,00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 169,033 169,033 72,00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 169,033 169,033 72,00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 66,943 466,943 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 66,943 466,943 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0			705, 258	994, 346	1, 699, 60	-15, 648		1
65. 00 66500 RESPIRATORY THERAPY			0	0		0 0	0	1
67.00 06700 06700 06200 0600			87, 185	70, 288	157, 47	3 -11, 116	146, 357	
68.00 06800 SPEECH PATHOLOGY 18, 600 31, 413 50, 013 -26, 688 23, 325 88. 00 06900 ELECTROCARDI OLOGY 229, 580 55, 661 285, 241 -12, 369 272, 872 69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 223, 988 223, 988 71. 00 73.00 07300 PRUSS CLARGED TO PATIENTS 0 0 0 0 0 0 466, 943 466, 943 73. 00 73.00 07300 PRUSS CLARGED TO PATIENTS 0 0 0 0 0 0 466, 943 466, 943 73. 00 73.00 07300 PRUSS CLARGED TO PATIENTS 0 0 0 0 0 0 466, 943 466, 943 73. 00 73.00								
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OUTPATT ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 2,647,996 1,008,555 3,656,551 -149,918 3,506,633 88.00 88.01 08801 RURAL HEALTH CLINIC 11 772,987 382,853 1,155,840 -64,393 1,091,447 88.01 88.02 08802 RURAL HEALTH CLINIC (RHC) 235,157 86,614 321,771 6,192 327,963 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 89.00 09000 FEDERALLY QUALIFIED HEALTH CENTER 112,589 487,427 600,016 -35,464 564,552 90.00 90.00 09000 FEDERALLY QUALIFIED HEALTH CENTER 3,182,197 536,443 3,718,640 -106,190 3,612,450 91.00 92.00 08ERGENCY 3,182,197 536,443 3,718,640 -106,190 3,612,450 91.00 92.00 08ERGENCY 09200 08ERGENCY 09910 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		·		•
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88. 01 08801 RURAL HEALTH CLINIC II 772, 987 382, 853 1,155, 840 -64, 393 1,091,447 88. 01 88. 02 08802 RURAL HEALTH CLINIC (RHC) 235, 157 86,614 321,771 6, 192 327,963 88. 02 99. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 89. 00 99. 00 09000 CLINIC 112,589 487, 427 600,016 -35, 464 564, 552 90. 00 9000 DEBERGENCY 3, 182, 197 536, 443 3,718, 640 -106, 190 3, 612, 450 91. 00 91. 00 0900 DEBERGENCY 3, 182, 197 536, 443 3,718, 640 -106, 190 3, 612, 450 91. 00 91. 00 0910 DEBERGENCY 99. 10 0910 DEBERGENCY 99.	00 00		2 (47 00)	1 000 555	2 (5(55	1 140 010	2 50/ /22	00.00
88.02 08802 RURAL HEALTH CLINIC (RHC) 235, 157 86, 614 321, 771 6, 192 327, 963 88.02 99.00 09000 EDERRALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 92.00								
89.00 8900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89.00								
91. 00			0	0		0 0		•
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0			1		1			1
99. 10 OFFICE RELIMBURSABLE COST CENTERS 109. 10 OFFICE O			3, 182, 197	536, 443	3, 718, 64	-106, 190	3, 612, 450	
99. 10 09910 CORF COST CENTERS O O O O O O O O O O O O O O O O O O	92.00							92.00
SPECIAL PURPOSE COST CENTERS 109, 00 10900 PANCREAS ACQUI SITI ON 0 0 0 0 0 0 109, 00 110, 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 0 0 0 111, 00 111, 00 ISLET ACQUI SITI ON 0 0 0 0 0 0 111, 00 111, 00 ISLET ACQUI SITI ON 0 0 0 0 0 0 111, 00 111, 00 ISLET ACQUI SITI ON 0 0 0 0 0 0 111, 00 113, 00 113, 00 113, 00 113, 00 INTEREST EXPENSE 0 0 0 0 0 0 113, 00 113, 00 INTEREST EXPENSE 0 0 0 0 0 0 113, 00 113,	99. 10		0	0		0 0	0	99. 10
110.00 11000 1 NTESTI NAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 1 SLET ACQUISITION 0 0 0 0 0 0 113.00 11300 1 NTEREST EXPENSE 0 0 0 0 0 0 113.00 11300 1 NTEREST EXPENSE 0 0 0 0 0 114.00 113.00 1 NTEREST EXPENSE 0 0 0 0 0 115.00 1 NTEREST EXPENSE 0 0 0 0 0 115.00 1 NTEREST EXPENSE 0 0 0 0 0 115.00 1 NTEREST EXPENSE 0 0 0 0 0 115.00 1 NTEREST EXPENSE 0 0 0 0 0 115.00 1 NTEREST EXPENSE 0 0 0 0 115.00 1 NTER		SPECIAL PURPOSE COST CENTERS						1
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113. 00 11300 1 NTEREST EXPENSE 0 0 0 0 0 113. 00 118. 00 118. 00			0	0		0		
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 13,698,274 13,031,551 26,729,825 0 26,729,825 118.00			U U	0		0 0		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192.00 192.00 192.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 194.			13, 698, 274	13, 031, 551	26, 729, 82	5 0		
191. 00 19100 RESEARCH								1
192. 00 19200 19200 19200 19200 1930			0	0				
193. 00 19300 NONPAI D WORKERS			0	0		0		
194. 00 07950 TOWN & COUNTRY RHC BLD 0 0 0 194. 00 194. 01 194. 01 07951 WOODFORD PUBLIC HEALTH 0 0 0 0 194. 01 194. 02 07952 RENTAL PROPERTIES 0 0 0 0 194. 02 194. 03 07953 EDUCATION 0 0 0 0 194. 03 194. 04 07954 SCHOOL THERAPY 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 194. 05 07955 VACANT SPACE 0 0 0 0 194. 05 07950 0 0 0 0 0 0 0 0 0				0		0 0		
194. 02 07952 RENTAL PROPERTIES 0 0 0 0 194. 02 194. 03 07953 EDUCATION 0 0 0 0 194. 03 194. 04 07954 SCHOOL THERAPY 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05			O	0		0 0		
194. 03 07953 EDUCATI ON 0 0 0 194. 03 194. 04 07954 SCHOOL THERAPY 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05			0	0		0		
194. 04 07954 SCHOOL THERAPY 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 194. 05			0	0		0 0		
194. 05 07955 VACANT SPACE 0 0 0 0 194. 05				0		0		
				0		o o		
			13, 698, 274	13, 031, 551	26, 729, 82			

Heal th	Financial Systems	CARLE EUREKA	A HOSPITAL		In Lieu of Form	CMS-2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CCN:	: 14-1309	Peri od: Worksheet	
					From 01/01/2023 To 12/31/2023 Date/Time	e Prepared:
					5/29/2024	4 8:55 pm
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8)	For Allocation			
	GENERAL SERVICE COST CENTERS	6. 00	7.00			
1.00	00100 CAP REL COSTS-BLDG & FLXT	461, 363	232, 779			1.00
1. 01	00101 NEW 2016 BUILDING & FIXT ADDITION	0	183, 189			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0			2. 00
3.00	00300 OTHER CAP REL COSTS	0	0			3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	405, 720	405, 720			4. 00
5. 01	00590 OTHER ADMINISTRATIVE AND GENERAL	-475, 689	1			5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	1, 291, 246				5. 02
7.00	00700 OPERATION OF PLANT	946, 823	1			7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	0	0 318, 350			8. 00 9. 00
10. 00	01000 DI ETARY	-659				10.00
13. 00	01300 NURSING ADMINISTRATION	582, 430	1			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	321, 541	404, 378			14. 00
15. 00	01500 PHARMACY	7, 867	1, 074, 833			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1			16. 00
17. 00	01700 SOCIAL SERVICE	0	1			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0			19. 00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 830, 350			30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0				33.00
41. 00	04100 SUBPROVI DER - I RF	0	1			41. 00
42.00	04200 SUBPROVI DER	0	1			42. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATI NG ROOM	0	956, 849			50. 00
53.00	05300 ANESTHESI OLOGY	0	438, 484			53.00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	1, 252, 685			54. 00 57. 00
58. 00	05800 MRI	0				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	l o			59. 00
60.00	06000 LABORATORY	0	1, 683, 956			60.00
60. 01	06001 BLOOD LABORATORY	0	0			60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0			64. 00
65. 00	06500 RESPI RATORY THERAPY	0	146, 357			65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	616, 516 161, 349			66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	23, 325			68. 00
69. 00	06900 ELECTROCARDI OLOGY	-7, 980	1			69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	223, 988			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	169, 033			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	466, 943			73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		2 507 722			00.00
88. 00 88. 01	O8800 RURAL HEALTH CLINIC O8801 RURAL HEALTH CLINIC II	0 -12				88. 00 88. 01
	08802 RURAL HEALTH CLINIC (RHC)	-352	327, 611			88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1 1			89. 00
90.00	09000 CLI NI C	-410, 828	153, 724			90.00
91. 00	09100 EMERGENCY	-1, 170, 352	2, 442, 098			91.00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART					92. 00
00 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0			99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	0	<u> </u>			77. 10
109.00	10900 PANCREAS ACQUISITION	0	0			109. 00
	11000 INTESTINAL ACQUISITION	0	0			110. 00
	11100 I SLET ACQUI SI TI ON	0	0			111. 00
	11300 I NTEREST EXPENSE	0	0			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 951, 118	28, 680, 943			118. 00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0			190, 00
	19100 RESEARCH	0	1			191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	o			192. 00
193.00	19300 NONPALD WORKERS	0	o			193. 00
	07950 TOWN & COUNTRY RHC BLD	0	o			194. 00
	07951 WOODFORD PUBLIC HEALTH	0	0			194. 01
	07952 RENTAL PROPERTI ES	0	0			194. 02
	07953 EDUCATION	0				194. 03 194. 04
	07954 SCHOOL THERAPY 07955 VACANT SPACE	0	0			194. 04
200.00		1, 951, 118	28, 680, 943			200.00

Health Financial Systems RECLASSIFICATIONS CARLE EUREKA HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet A-0
From 01/01/2023
To 12/31/2023 Date/Ti me Prepared: 5/29/2024 8:55 pm Provider CCN: 14-1309

					 5/29/2024 8:	55 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
1 00	A - RECLASS DRUGS CHARGED TO			4// 042		1 00
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	466, 943		1.00
2.00		0. 00 0. 00	0	- 1		2.00
3. 00 4. 00		0.00	0	0		3. 00 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	Ö		8.00
0.00	TOTALS		— — <u> </u>			0.00
	B - CRNA RECLASS	<u> </u>		1007 7 10		
1.00			0	0		1. 00
	C - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	223, 988		1. 00
	PATI ENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	169, 033		2. 00
0.00	PATI ENTS		=	_		0.00
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 7. 00		0. 00 0. 00	0	0		6.00
7.00	TOTALS — — — —	— — 0.00				7. 00
	D - INTERNAL RENT			373, 021		
1.00	OTHER ADMINISTRATIVE AND	5. 01	0	1, 166, 208		1.00
1.00	GENERAL STRATT VE AND	3.01	O	1, 100, 200		1.00
2.00		0.00	0	0		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	_		9. 00
10. 00		0.00	0	_		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0			12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	- 1		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17. 00		0.00	0	_		17. 00 18. 00
18.00		0. 00 0. 00	0	0		19.00
19. 00	TOTALS — — — —			1, 166, 208		19.00
	E - BUILDING DEPRECIATION		0	1, 100, 200		1
1. 00	NEW 2016 BUILDING & FIXT	1. 01	0	186, 485		1.00
1.00	ADDITION	'.01	0	100, 400		1.00
2.00		0.00	0	0		2. 00
	TOTALS — — — —	 	- _ - 0	186, 485		
	F - HOME OFFICE UTILITIES					
1.00	OPERATION OF PLANT	7. 00	0			1. 00
2.00	RURAL HEALTH CLINIC	88. 00	0	8, 146		2. 00
3.00	RURAL HEALTH CLINIC II	88. 01	0			3. 00
4.00	RURAL HEALTH CLINIC (RHC)	8802	0	<u>6, 1</u> 92		4. 00
	TOTALS		0	478, 387		1
	K - EL PASO RHC BUILDING DEPF			,		
1.00	RURAL HEALTH CLINIC II	88. 01	0			1. 00
2.00		0.00	0	0		2. 00
	TOTALS		0	10,070		
500.00	Grand Total: Increases		0	2, 736, 439		500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 8:55 pm Provider CCN: 14-1309

						5/29/2024 8:	55 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10. 00		
	A - RECLASS DRUGS CHARGED TO	PATI ENTS					
1.00	PHARMACY	15. 00	0	421, 974	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	o	327	0		2. 00
3.00	OPERATING ROOM	50.00	0	195	0		3. 00
4.00	RESPIRATORY THERAPY	65. 00	0	1, 660	0		4. 00
5. 00	PHYSI CAL THERAPY	66.00	o	191	0		5. 00
6.00	ELECTROCARDI OLOGY	69. 00	o	7, 209	0		6. 00
7. 00	CLINIC	90.00	0	35, 102	0		7. 00
8. 00	EMERGENCY	91.00	0	285	0		8. 00
0.00	TOTALS	71.00	— —)	466, 943			0.00
	B - CRNA RECLASS		<u> </u>	400, 743			-
1.00	D - CRIMA RECEASS		0	0			1.00
1.00			— — — ‡	$\frac{0}{0}$			1.00
	C - RECLASS MEDICAL SUPPLIES		U _I	U			-
1. 00	CENTRAL SERVICES & SUPPLY	14.00	0	13	0		1.00
2. 00	OPERATING ROOM	50.00	0	152, 795	0		2. 00
3.00	ANESTHESI OLOGY	53.00	0		0		3. 00
4. 00	PHYSI CAL THERAPY	66.00	0	16, 394 227	0		1
	l .		0		0		4. 00
5.00	CLINIC	90.00	0	362			5. 00
6.00	EMERGENCY	91.00	0	54, 197	0		6. 00
7. 00	OPERATING ROOM	50.00		169, 033	0		7. 00
	TOTALS		0	393, 021			_
4 00	D - INTERNAL RENT	F 04	ما	47.500			4
1. 00	OTHER ADMINISTRATIVE AND	5. 01	0	17, 580	0		1. 00
2 00	GENERAL	F 00		117 504	0		2 00
2. 00	OTHER ADMINISTRATIVE AND	5. 02	0	117, 504	0		2. 00
2 00	GENERAL OF BLANT	7.00		100 444	0		2 00
3.00	OPERATION OF PLANT	7.00	0	180, 444	0		3. 00
4.00	HOUSEKEEPI NG	9.00	0	15, 468	0		4. 00
5.00	DIETARY	10.00	0	30, 564	0		5. 00
6.00	NURSING ADMINISTRATION	13.00	0	3, 660	0		6. 00
7.00	PHARMACY	15.00	0	1, 704	0		7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	172, 440	0		8. 00
9.00	OPERATING ROOM	50.00	O	154, 908	0		9. 00
10. 00	ANESTHESI OLOGY	53. 00	O	4, 236	0		10. 00
11. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	44, 676	0		11. 00
12. 00	LABORATORY	60.00	0	15, 648	0		12. 00
13. 00	RESPI RATORY THERAPY	65.00	0	9, 456	0		13. 00
14. 00	PHYSI CAL THERAPY	66. 00	0	26, 616	0		14. 00
15. 00	SPEECH PATHOLOGY	68. 00	0	26, 688	0		15. 00
16. 00	ELECTROCARDI OLOGY	69. 00	0	5, 160	0		16. 00
17.00	RURAL HEALTH CLINIC	88.00	0	158, 064	0		17. 00
18.00	RURAL HEALTH CLINIC II	88. 01	0	129, 684	0		18. 00
19.00	EMERGENCY	91.00	O	51, 708	0		19. 00
	TOTALS — — — — —		— — -	1, 166, 208			1
	E - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	186, 485	9		1. 00
2.00		0.00	0	0	9		2. 00
	TOTALS			186, 485			
	F - HOME OFFICE UTILITIES						
1.00	OTHER ADMINISTRATIVE AND	5. 01	0	478, 387	0		1. 00
	GENERAL						
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00	L		•	0	0		4. 00
	TOTALS		0	478, 387			
	K - EL PASO RHC BUILDING DEPF						4
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	42, 099	9		1. 00
2.00	NEW 2016 BUILDING & FIXT	1. 01	0	3, 296	9		2. 00
	ADDITION						
	TOTALS		0	45, 395			
500.00	Grand Total: Decreases		0	2, 736, 439			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARLE EUREKA HOSPITAL Provider CCN: 14-1309

				To	12/31/2023	Date/Time Prep 5/29/2024 8:5	
				Acqui si ti ons		372772024 0. 3.	J piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	380, 000	0	0	0	0	1.00
2.00	Land Improvements	1, 550, 399	15, 909	0	15, 909		2. 00
3.00	Buildings and Fixtures	22, 115, 988	82, 806	0	82, 806	0	3. 00
4. 00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	5, 612, 347	766, 595	0	766, 595	0	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	29, 658, 734	865, 310	0	865, 310	0	8. 00
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	29, 658, 734	865, 310	0	865, 310	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1. 00	Land	380, 000	0				1. 00
2.00	Land Improvements	1, 566, 308	0				2. 00
3. 00	Buildings and Fixtures	22, 198, 794	0				3. 00
4.00	Building Improvements	0	0				4. 00
5. 00	Fi xed Equi pment	0	0				5. 00
6. 00	Movable Equipment	6, 378, 942	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	30, 524, 044	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	30, 524, 044	0				10. 00

Health Financial Systems	CARLE EUREKA HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 14-1309	Peri od: From 01/01/2023 To 12/31/2023		pared:
			SUMMARY OF CAF	PITAL		·
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 WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00 CAP REL COSTS-BLDG & FLXT	0		0	0 0	0	1. 00
1.01 NEW 2016 BUILDING & FIXT ADDITION	0		0	0 0	0	1. 01
2.00 CAP REL COSTS-MVBLE EQUIP	0		0	0 0	0	2. 00
3.00 Total (sum of lines 1-2)	0		0	0 0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (su	ım			
	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	and 2			
1.00 CAP REL COSTS-BLDG & FLXT	0		0			1. 00
1.01 NEW 2016 BUILDING & FIXT ADDITION	0		0			1. 01
2.00 CAP REL COSTS-MVBLE EQUIP	0		0			2. 00
3.00 Total (sum of lines 1-2)	0		0			3. 00

Heal th	n Financial Systems	CARLE EUREKA	A HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 8:55	pared:
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	475, 213		475, 21			1. 00
1. 01	NEW 2016 BUILDING & FIXT ADDITION	7, 123, 792		7, 123, 79			1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	3, 215, 214		3, 215, 21			2.00
3.00	Total (sum of lines 1-2)	10, 814, 219		10, 814, 21			3. 00
		TION OF OTHER (OF CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		1			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 232, 779		1.00
1. 01	NEW 2016 BUILDING & FIXT ADDITION	0	0		0 183, 189		1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 415, 968	0	3. 00
			Sl 	JMMARY OF CAPI	TAL		
	Cost Center Description		Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			1			
1.00	CAP REL COSTS-BLDG & FIXT	0	Ĭ		0		1. 00
1. 01	NEW 2016 BUILDING & FIXT ADDITION	0	0	1	0	183, 189	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	415, 968	3.00

					To 12/31/2023		
				Expense Classification on To/From Which the Amount is		5/29/2024 8: 55	5 pm
				10/11 oill will cit the Amount 13	to be Aujusteu		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00		1. 0
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - NEW 2016 BUILDING & FIXT ADDITION			NEW 2016 BUILDING & FIXT ADDITION	1.01	0	1. 0
2. 00	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 0
. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 0
. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 0
. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 0
. 00	Rental of provider space by suppliers (chapter 8)		O		0. 00	0	6. 0
7. 00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	O	7. 0
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 0
0. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -1, 576, 180		0.00	0	9. 00 10. 00
1. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 0
2. 00	Related organization transactions (chapter 10)	A-8-1	4, 038, 687			0	12. 0
3. 00 4. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -659	DI ETARY	0. 00 10. 00		13. 0 14. 0
5. 00	Rental of quarters to employee and others		0		0.00	0	15. 0
6. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 0
7. 00	Sale of drugs to other than patients		0		0.00	0	17. 0
8. 00	Sale of medical records and abstracts		0		0. 00	0	18. 0
9. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	O	19. 0
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty		0		0. 00 0. 00		
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	О	22. 0
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPIRATORY THERAPY	65.00		23. 0
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 0
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 0
6. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. C
6. 01	Depreciation - NEW 2016 BUILDING & FIXT ADDITION			NEW 2016 BUILDING & FIXT ADDITION	1. 01	0	26. 0
7. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 0
8. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.0
9. 00 0. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00		29. C 30. C
80. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 9

From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					To 12/31/2023	Date/Time Prep 5/29/2024 8:5	
				Expense Classification or To/From Which the Amount is			o piii
				10/FION WHICH THE AMOUNT IS	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
04.00		1.00	2. 00	3. 00	4. 00	5. 00	24 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	U	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest OTHER OPERATING REVENUE	В	_21_130	OTHER ADMINISTRATIVE AND	5. 02	0	33. 00
				GENERAL			
33. 01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 01
33. 02 33. 03	OTHER OPERATING REVENUE OTHER OPERATING REVENUE	B B		EMERGENCY ELECTROCARDI OLOGY	91. 00 69. 00		33. 02 33. 03
33. 04	OTHER OPERATING REVENUE	В		OTHER ADMINISTRATIVE AND	5. 01		33. 04
33. 05	OTHER OPERATING REVENUE		0	GENERAL	0.00	0	33. 05
33. 06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 06
33. 07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 07
33. 08	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 08
33. 09	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 09
33. 10	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 10
33. 11	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 11
33. 12	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 12
33. 13	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 13
33. 14	(3) ADVERTI SI NG	A	-567	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	33. 14
33. 15	IDPA TAX ASSESSMENT	A	-475, 100	OTHER ADMINISTRATIVE AND GENERAL	5. 01	0	33. 15
33. 16	ADVERTI SI NG	Α		RURAL HEALTH CLINIC II	88. 01	9	33. 16
33. 17 33. 18	ADVERTISING OTHER ADJUSTMENTS (SPECIFY)	A	-352 0	RURAL HEALTH CLINIC (RHC)	88. 02 0. 00		33. 17 33. 18
33. 19	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 19
33. 20	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00		33. 20
33. 21	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 21
33. 22	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 22
33. 23	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 23
33. 24	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 24
33. 25	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 25
33. 26	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 26
33. 27	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 27
33. 28	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 28
50. 00	(3) TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1, 951, 118				50. 00

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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1309 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/0

				12/01/2020	5/29/2024 8: 5				
	Li ne No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost	Included in				
					Wks. A, column				
					5				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:		<u>, </u>						
1.00	7. 00	OPERATION OF PLANT	MAI NTENANCE	946, 823	0	1.00			
2.00	13. 00	NURSING ADMINISTRATION	PATIENT CARE	582, 430	0	2.00			
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	405, 720	0	3.00			
4.00	14. 00	CENTRAL SERVICES & SUPPLY	SPD	321, 541	0	4.00			
4.03	5. 02	OTHER ADMINISTRATIVE AND GEN	A&G	6, 000, 443	4, 458, 067	4. 03			
4.04	5. 02	OTHER ADMINISTRATIVE AND GEN	INTERNAL RENT	936, 775	1, 166, 208	4.04			
4.05	15. 00	PHARMACY	349B	7, 867	0	4.05			
4.06	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	461, 363	0	4.06			
4.07	0.00			0	0	4. 07			
5.00	TOTALS (sum of lines 1-4).			9, 662, 962	5, 624, 275	5.00			
	Transfer column 6, line 5 to								
	Worksheet A-8, column 2,								
	line 12.								
+ TL-				-l A I	/ !!				

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

1105 110	The been posted to norksheet h, cordinas i diditor 2, the disount differential of the beat to the beat										
				Related Organization(s) and/	or Home Office						
						ľ					
	Symbol (1)	Name	Percentage of	Name	Percentage of						
			Ownershi p		Ownershi p						
	1. 00	2. 00	3.00	4. 00	5. 00						
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:										

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

. o. mou.	Comont under the tro Attition		
6.00	В	O. OO ADVOCATE HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems		CARLE EUREKA H	OSPI TAL		In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATION	ONS AND HOME	Provi der	CCN: 14-1309	Peri od:	Worksheet A-	3-1
OFFICE	COSTS						From 01/01/2023		
							To 12/31/2023		
								5/29/2024 8:	ob pm
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A	RESULT OF TRA	NSACTI ONS	WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO:	STS:							
1.00	946, 823	9							1.00
2.00	582, 430	9							2.00
3.00	405, 720	9							3.00
4.00	321, 541	C							4.00
4.03	1, 542, 376	C							4. 03
4.04	-229, 433	C							4. 04
4.05	7, 867	C							4. 05
4.06	461, 363	9)						4. 06
4 07		۱ .	ار						4 07

5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

5.00

 The second secon	cordinate i diagraf 2, the discourt difference of cordinate of the cordinate for the partit	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HEALTHCARE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
9. 00 10. 00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Provider CCN: 14-1309

						10 12/31/2023	5/29/2024 8:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component	1102 711104111	i der Component	
							Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	0. 00		0	0	0	C	0	1. 00
2.00	91. 00	EMERGENCY	1, 856, 426	1, 165, 352	691, 074	l c	0	2. 00
3.00	90. 00	CLINIC	410, 828	410, 828	0	l c	0	3. 00
4.00	0. 00		0	0	0	l c	0	4. 00
5.00	0. 00		0	0	0	l c	0	5. 00
6.00	0.00		0	0	0	l c	0	6. 00
7.00	0.00		0	0	0	l c	0	7. 00
8.00	0.00		0	0	0	l c	0	8. 00
9.00	0.00		0	0	0	l c	0	9. 00
10.00	0.00		0	0	0	l c	0	10.00
200.00			2, 267, 254	1, 576, 180	691, 074		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	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	0. 00		0			-		
2.00		EMERGENCY	0		0	C	0	
3.00		CLINIC	0	0	0	C	0	
4. 00	0. 00		0	0	0	C	0	
5.00	0. 00		0	0	0	C	0	
6.00	0. 00		0	0	0	C	0	1
7. 00	0. 00		0	0	0	C	0	
8. 00	0. 00		0	0	0	C	0	
9. 00	0. 00		0	0	0	C	0	
10.00	0. 00		0	0	_		0	
200.00	18/1 1 A 1 . //	0 1 0 1 (8)	0	0	_		0	200.00
	Wkst. A Line #	,	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	†	
1. 00	0.00	2. 00	0	0				1, 00
2. 00		EMERGENCY	0	0	0	1, 165, 352		2.00
3. 00		CLINIC	0	0	0	410, 828		3. 00
4. 00	0.00		0	0	0	0	1	4. 00
5. 00	0.00		0	0	0	l d		5. 00
6. 00	0. 00		0	0	0	1 0		6. 00
7. 00	0. 00		0	l o	0	1 0		7. 00
8. 00	0. 00		0	l o	_	1 0		8. 00
9. 00	0. 00		l o		_	1 0		9. 00
10. 00	0. 00		0	Ö	0			10.00
200.00			0	Ö	0	1, 576, 180		200.00
	•	1		•	1		•	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri o Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1309

				11	0 12/31/2023	Date/lime Pre 5/29/2024 8:5	
			CAP	I TAL RELATED CO	STS	0,27,2021 0.0	O PIII
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		col . 7)	1.00		0.00	4.00	
	OFNEDAL CEDIU OF COST OFNITEDS	0	1. 00	1. 01	2. 00	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	232, 779	232, 779	1			1.00
1. 00	00101 NEW 2016 BUILDING & FIXT ADDITION	183, 189	232, 117	183, 189			1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	103, 109		103, 109	0		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	405, 720	0		0	405, 720	4.00
5. 01	00590 OTHER ADMINISTRATIVE AND GENERAL	673, 869	40, 565		0	10, 404	5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	6, 534, 049	24, 212		0	12, 073	5. 02
7.00	00700 OPERATION OF PLANT	1, 784, 462	28, 448		0	9, 021	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	2, 156		0	0	8. 00
9.00	00900 HOUSEKEEPI NG	318, 350	3, 391		0	5, 310	9. 00
10.00	01000 DI ETARY	283, 459	6, 690	0	0	5, 544	10.00
13.00	01300 NURSING ADMINISTRATION	1, 029, 627	801	0	0	9, 742	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	404, 378	0	0	0	1, 232	14. 00
15. 00	01500 PHARMACY	1, 074, 833	0	0	0	7, 861	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 700	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 830, 350	9, 657	71, 902	0	38, 603	30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	1, 630, 330	9,007) 71, 902	0		33.00
41. 00	04100 SUBPROVI DER – I RF		0	0	0	l	41.00
42. 00	04200 SUBPROVI DER	0	o o	· -	0	l	42.00
12.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		<u>, </u>			12.00
50.00	05000 OPERATI NG ROOM	956, 849	5, 123	72, 476	0	18, 793	50.00
53.00	05300 ANESTHESI OLOGY	438, 484	1, 964	0	0	11, 603	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 252, 685	7, 958	2, 152	0	20, 446	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00	06000 LABORATORY	1, 683, 956	3, 010	0	0	20, 888	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	144 257		0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	146, 357	546 5, 819	•	0	2, 582	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	616, 516 161, 349	4, 425		0	14, 738 3, 651	67.00
68. 00	06800 SPEECH PATHOLOGY	23, 325	5, 842		0	551	68. 00
69. 00	06900 ELECTROCARDI OLOGY	264, 892	1, 129		0	6, 800	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	223, 988	341		0	0,000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	169, 033	0	· ·	0	Ō	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	466, 943	O	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	3, 506, 633	34, 360				
	08801 RURAL HEALTH CLINIC II	1, 091, 435	29, 521	0	0	,,	1
	08802 RURAL HEALTH CLINIC (RHC)	327, 611	0	0	0	6, 965	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	450.704	0	0	0	0	89. 00
90.00	09000 CLI NI C 09100 EMERGENCY	153, 724	11 121	0	0	3, 335 94, 256	1
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 442, 098	11, 121		U	94, 230	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS					L	72.00
99. 10	09910 CORF	0	C	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	-	_				
	10900 PANCREAS ACQUISITION	0	O	0	0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
	11300 INTEREST EXPENSE						113. 00
118.00		28, 680, 943	232, 779	183, 189	0	405, 720	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
	19300 NONPALD WORKERS 07950 TOWN & COUNTRY RHC BLD		0		0	l	193. 00 194. 00
	07951 WOODFORD PUBLIC HEALTH		0		0	l e	194. 00
	07952 RENTAL PROPERTIES		n		0		194. 02
	07953 EDUCATI ON		n	0	0		194. 03
	07954 SCHOOL THERAPY		Ö	o o	0		194. 04
	07955 VACANT SPACE	o	0	0	0		194. 05
200.00							200. 00
201.00	Negative Cost Centers		0	0	0	0	201. 00

Health Financial Systems	CARLE EUREK	CARLE EUREKA HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	F	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/29/2024 8:5			
		CAP	ITAL RELATED C	OSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)		NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT			
	0	1. 00	1. 01	2. 00	4. 00			
202.00 TOTAL (sum lines 118 through 20	28, 680, 943	3 232, 779	183, 189	0	405, 720	202.00		

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/29/2024 8:55 pm

			'	0 12/31/2023	5/29/2024 8:5	
Cost Center Description	Subtotal	OTHER	Subtotal	OTHER	OPERATION OF	
		ADMI NI STRATI VE		ADMI NI STRATI VE	PLANT	
	4.0	AND GENERAL	EA 01	AND GENERAL	7.00	
GENERAL SERVICE COST CENTERS	4A	5. 01	5A. 01	5. 02	7. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 NEW 2016 BUILDING & FIXT ADDITION						1. 01
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01 00590 OTHER ADMINISTRATIVE AND GENERAL	724, 838	724, 838				5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL	6, 574, 219	205, 457	6, 779, 676	6, 779, 676		5. 02
7.00 O0700 OPERATION OF PLANT	1, 852, 639	57, 901	1, 910, 540	591, 419	2, 501, 959	1
8.00 00800 LAUNDRY & LINEN SERVICE	2, 156				47, 202	1
9. 00 00900 HOUSEKEEPI NG	327, 768				65, 762	1
10. 00 01000 DI ETARY 13. 00 01300 NURSI NG ADMI NI STRATI ON	295, 693		304, 934		129, 725	1
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	1, 040, 170 405, 610				15, 541 0	1
15. 00 01500 PHARMACY	1, 082, 694				7, 257	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	5, 700				110, 523	1
17. 00 01700 SOCIAL SERVICE	0			0	0	1
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS			T	1		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 950, 512 0		2, 011, 471	622, 663	740, 331 0	1
33. 00 03300 BURN I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	
42. 00 04200 SUBPROVI DER	Ö	0	٥	o	0	1
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 053, 241	32, 917			644, 387	1
53. 00 05300 ANESTHESI OLOGY	452, 051	14, 128			38, 083	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 283, 241	40, 105	1, 323, 346	409, 650	170, 505	1
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	0		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60. 00 06000 LABORATORY	1, 707, 854	53, 376	1, 761, 230	545, 199	58, 376	1
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00 06500 RESPI RATORY THERAPY	149, 485				10, 596	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	637, 073 169, 425				112, 835 113, 285	1
68. 00 06800 SPEECH PATHOLOGY	29, 718				113, 263	1
69. 00 06900 ELECTROCARDI OLOGY	272, 821	8, 526			21, 899	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	225, 678				0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	169, 033				0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	466, 943	14, 593	481, 536	149, 062	0	73. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	2 (10 421	1 0	3, 619, 421	1 120 410	0	00 00
88.00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC II	3, 619, 421 1, 143, 850		1, 143, 850		0	
88. 02 08802 RURAL HEALTH CLINIC (RHC)	334, 576				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	157, 059	4, 909	161, 968	50, 138		
91. 00 09100 EMERGENCY	2, 547, 475				215, 652	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0		0			92. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS					U	//. 10
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 INTEREST EXPENSE	00 (00 040	704 000	00 (00 040	, 770 ,71	0 504 050	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	28, 680, 943	724, 838	28, 680, 943	6, 779, 676	2, 501, 959]118.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
191. 00 19100 RESEARCH	0		٥	Ö		191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 TOWN & COUNTRY RHC BLD	0	0	0	0		194. 00
194. 01 07951 WOODFORD PUBLIC HEALTH	0	0	0	0		194. 01
194. 02 07952 RENTAL PROPERTI ES 194. 03 07953 EDUCATI ON	0			0		194. 02 194. 03
194. 04 07954 SCHOOL THERAPY	0	0	0	0		194. 03
194. 05 07955 VACANT SPACE	Ö	0	Ö	ő		194. 05
200.00 Cross Foot Adjustments	0		0			200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	28, 680, 943	724, 838	28, 680, 943	6, 779, 676	2, 501, 959	J202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/29/2024 8:55 pm

				'	0 12/31/2023	5/29/2024 8: 5	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
		8.00	9. 00	10.00	13.00	SUPPLY 14. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW 2016 BUILDING & FIXT ADDITION 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 OTHER ADMINISTRATIVE AND GENERAL 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 19900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	50, 113 0 0 0 0 0 0 0	508, 408 10, 992 0 11, 814 0 0 0		1, 420, 273 0 0 0 0 0 0	559, 584 0 0 0 0	1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00 17. 00
30.00	03000 ADULTS & PEDI ATRI CS	15, 386	119, 988	540, 045	589, 946	0	30. 00
33. 00 41. 00 42. 00	03300 BURN INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER ANCILLARY SERVICE COST CENTERS	0 0	0 0 0	0	,	0 0 0	33. 00 41. 00 42. 00
50.00	05000 OPERATING ROOM	5, 911	73, 246	C	241, 962	0	50.00
53. 00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 386	36, 777	C	0	0	54. 00
57. 00	05700 CT SCAN	0	0	C	0	0	57. 00
58. 00 59. 00	05800 MRI	0	0		0	0	58.00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY		16, 745			0	59. 00 60. 00
60. 00	06001 BL00D LABORATORY	0	10, 745			0	60.00
64. 00	06400 NTRAVENOUS THERAPY	0	0			0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	17, 464		o o	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 719	39, 140		o	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	l c	o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	686	3, 185	C	66, 054	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	319, 056	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	240, 485	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	0		0	0	88. 02
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	493	43, 865		21, 917	0	89. 00 90. 00
91.00	09100 EMERGENCY	19, 532					
	09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 332	133, 172		300, 200	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 10	09910 CORF	0	0	C	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	C	0		109. 00
	11000 INTESTINAL ACQUISITION	0	0	1			110. 00
	11100 SLET ACQUISITION	0	0	C	0	0	111. 00
	11300 INTEREST EXPENSE			540.045			113.00
118.00		50, 113	508, 408	540, 045	1, 420, 139	559, 541	1118. 00
100.00	NONREI MBURSABLE COST CENTERS					0	100 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0		0		190. 00 191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0				192.00
	19300 NONPALD WORKERS	0	0				193. 00
	07950 TOWN & COUNTRY RHC BLD	0	0	ĺ	o o		194. 00
	07951 WOODFORD PUBLIC HEALTH	0	0	ĺ	o o		194. 01
	07952 RENTAL PROPERTIES	O	Ö		ol o		194. 02
194. 03	07953 EDUCATI ON	0	0	C	134	43	194. 03
194.04	07954 SCHOOL THERAPY	0	0	C	0	0	194. 04
	07955 VACANT SPACE	0	0	[C	0	0	194. 05
200.00	, ,						200. 00
201.00		_ 0	0	C	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	50, 113	508, 408	540, 045	1, 420, 273	559, 584	J202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/29/2024 8:55 pm

				!	0 12/31/2023	5/29/2024 8: 5	
	Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Į į
		15. 00	16. 00	17. 00	19. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 01	00101 NEW 2016 BUILDING & FIXT ADDITION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 01	OO4OO	1					4. 00 5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE]					8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	-					13. 00 14. 00
15. 00	01500 PHARMACY	1, 469, 417					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	118, 221				16.00
17. 00	01700 SOCI AL SERVI CE	o	0	0			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	TT		T	_		
30. 00	03000 ADULTS & PEDI ATRI CS	0	118, 221	0		.,	
33. 00 41. 00	03300 BURN INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0 0	0	0	_	0	
42. 00	04200 SUBPROVI DER	0	0	0	0	0	1
12.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			<u> </u>		12.00
50.00	05000 OPERATING ROOM	0	0	0	0	2, 387, 891	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0		648, 571	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	_	1, 946, 664	
57. 00	05700 CT SCAN	0	0	0	_	0	
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	1
60. 00	06000 LABORATORY		0	0	0	2, 381, 550	1
60. 01	06001 BLOOD LABORATORY	0	0	Ö	0	2,001,000	1
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	1
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	229, 937	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	1, 014, 050	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	342, 091	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	40, 134 460, 264	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	623, 830	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0	Ö	0	468, 762	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 469, 417	0	0	0		
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		_	., ,	
88. 01 88. 02	08801 RURAL HEALTH CLINIC II	0	0	0	0	1, 497, 936 451, 840	
89. 00	08802 RURAL HEALTH CLINIC (RHC) 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	431, 640	1
90. 00	09000 CLINIC	0	0	Ö	0	278, 381	1
	09100 EMERGENCY	o	0	Ō	0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS			_	_		
99. 10	O9910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
109 00	10900 PANCREAS ACQUISITION	O	0	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	_			110.00
	11100 SLET ACQUISITION	0	0	Ō	_		111. 00
113.00	11300 I NTEREST EXPENSE	1					113. 00
118. 00		1, 469, 417	118, 221	0	0	28, 680, 766	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	0	_		190. 00 191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	_		191.00
	19300 NONPALD WORKERS	0	0	Ö	0		193. 00
	07950 TOWN & COUNTRY RHC BLD	O	0	0	0		194. 00
	07951 WOODFORD PUBLIC HEALTH	0	0	0	0		194. 01
	07952 RENTAL PROPERTIES	0	0	0	0		194. 02
	07953 EDUCATI ON	0	0	0	0		194. 03
	07954 SCHOOL THERAPY 07955 VACANT SPACE	0	0		0		194. 04 194. 05
200.00		١	U	1			200.00
201.00	, ,	l	0	0	0	0	201.00
202.00		1, 469, 417	118, 221	0	0		

CARLE EUREKA HOSPITAL

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/29/2024 8:55 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1309

			10 12/31/2023	5/29/2024 8: 55 pm
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT				1. 00
1.01 O0101 NEW 2016 BUILDING & FIXT ADDITION				1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01 00590 OTHER ADMINISTRATIVE AND GENERAL				5. 01
5. 02 00560 OTHER ADMINISTRATIVE AND GENERAL				5. 02
7. 00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9. 00 10. 00
13. 00 O1300 NURSING ADMINISTRATION				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY				14. 00
15. 00 01500 PHARMACY				15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY		•		16. 00
17. 00 01700 SOCI AL SERVI CE				17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS				19. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	0	4, 758, 051		30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		33.00
41. 00 04100 SUBPROVI DER - RF	0	0		41. 00
42. 00 O4200 SUBPROVI DER	0	0		42. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	2 207 004		50.00
53. 00 05000 OPERATING ROOM 53. 00 05300 ANESTHESI OLOGY	0	2, 387, 891 648, 571		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		1, 946, 664		54.00
57. 00 05700 CT SCAN		1, 740, 004		57. 00
58. 00 05800 MRI		o		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	O	O		59. 00
60. 00 06000 LABORATORY	0	2, 381, 550		60.00
60. 01 06001 BLOOD LABORATORY	0	O		60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	0	229, 937		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 014, 050		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	342, 091		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	40, 134		68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	460, 264 623, 830		69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		468, 762		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		2, 100, 015		73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	27 1007 010		70.00
88. 00 08800 RURAL HEALTH CLINIC	0	4, 739, 840		88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	1, 497, 936		88. 01
88.02 08802 RURAL HEALTH CLINIC (RHC)	0	451, 840		88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90. 00 09000 CLI NI C	0	278, 381		90.00
91. 00 09100 EMERGENCY	0	4, 310, 959		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92. 00
OTHER REIMBURSABLE COST CENTERS	0	0		00.10
99. 10 O9910 CORF SPECIAL PURPOSE COST CENTERS	l ol	U		99. 10
109. 00 10900 PANCREAS ACQUISITION	O	O		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		o		110.00
111. 00 11100 SLET ACQUISITION	o	o		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	28, 680, 766		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 TOWN & COUNTRY RHC BLD		0		194. 00
194. 01 07951 WOODFORD PUBLIC HEALTH 194. 02 07952 RENTAL PROPERTIES		0		194. 01 194. 02
194. 03 07953 EDUCATION		177		194. 02
194. 04 07954 SCHOOL THERAPY		0		194. 04
194. 05 07955 VACANT SPACE		0		194. 05
200.00 Cross Foot Adjustments	o	o		200. 00
201.00 Negative Cost Centers	o	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	o	28, 680, 943		202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/29/2024 8:55 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1309

					12/31/2023	5/29/2024 8:5	
			CAP	TAL RELATED CO	STS		
	Cost Center Description	Di rectly Assi gned New Capi tal	BLDG & FIXT	NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP	Subtotal	
		Related Costs	4.00	4.04	0.00	0.4	
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	2. 00	2A	
1.00	00100 CAP REL COSTS-BLDG & FIXT			1			1.00
1.01	00101 NEW 2016 BUILDING & FIXT ADDITION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 01	00590 OTHER ADMINISTRATIVE AND GENERAL	0	40, 565	1	0	40, 565	1
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	0	24, 212		0	28, 097	5. 02
7.00	00700 OPERATION OF PLANT	700	28, 448		0	59, 856	1
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	2, 156 3, 391	0 717	0	2, 156 4, 108	1
10.00	01000 DI ETARY		6, 690	1	0	6, 690	1
13. 00	01300 NURSI NG ADMI NI STRATI ON		801	0	0	801	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	l o	0	ő	0	0	1
15. 00	01500 PHARMACY	0	O	0	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	9, 266	5, 700	0	0	14, 966	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 222	0.457	71 002	0	05 700	30.00
30. 00 33. 00	03000 ADULTS & PEDIATRICS 03300 BURN INTENSIVE CARE UNIT	4, 223 0	9, 657	71, 902 0	0	00,702	
41. 00	04100 SUBPROVI DER – I RF		0	0	0	l .	
42. 00	04200 SUBPROVI DER		0	1	0	l .	
	ANCILLARY SERVICE COST CENTERS	,	_				
50.00	05000 OPERATING ROOM	0	5, 123	72, 476	0	77, 599	50.00
53. 00	05300 ANESTHESI OLOGY	0	1, 964	1	0	.,	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	108, 333	7, 958	1	0	118, 443	1
57. 00	05700 CT SCAN	0	0	0	0	0	1
58. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	1
59. 00 60. 00	06000 LABORATORY		3, 010	0	0	3, 010	
60. 01	06001 BLOOD LABORATORY		3,010	0	0	0,010	1
64. 00	06400 I NTRAVENOUS THERAPY	o	0	ő	0	Ö	1
65.00	06500 RESPI RATORY THERAPY	0	546	0	0	546	1
66.00	06600 PHYSI CAL THERAPY	0	5, 819	0	0	5, 819	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	4, 425	1	0	4, 425	1
68. 00	06800 SPEECH PATHOLOGY	0	5, 842	1	0	5, 842	1
69. 00	06900 ELECTROCARDI OLOGY	0	1, 129	1	0	1, 129	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	341 0	1	0	1, 690 0	1
72.00	07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	1
73.00	OUTPATIENT SERVICE COST CENTERS	١		0	0	<u> </u>	73.00
88. 00	08800 RURAL HEALTH CLINIC	216, 714	34, 360	0	0	251, 074	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	8, 854	29, 521	0	0	38, 375	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	0	0	0	ľ	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	0	0	0	0	0	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11, 121	0	Ü	11, 121 0	1
92.00	OTHER REIMBURSABLE COST CENTERS					0	92.00
99. 10	09910 CORF	0	C	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	-1	-	-			1
109.00	10900 PANCREAS ACQUISITION	0	C	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0	•	110. 00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
	11300 INTEREST EXPENSE	0.40.000	770	400 400		7// 050	113. 00
118. 00	, , , , , , , , , , , , , , , , , , ,	348, 090	232, 779	183, 189	0	764, 058	1118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	l ol	0	0	0	0	190. 00
	19100 RESEARCH		0	0	0	l .	191.00
	19200 PHYSICIANS PRIVATE OFFICES	o	0	Ö	0	l	192. 00
	19300 NONPALD WORKERS	0	O	Ó	0		193. 00
194.00	07950 TOWN & COUNTRY RHC BLD	0	0	0	0	0	194. 00
	07951 WOODFORD PUBLIC HEALTH	0	0	0	0		194. 01
	07952 RENTAL PROPERTI ES	0	0	0	0		194. 02
	3 07953 EDUCATI ON	0	0	0	0		194. 03
	07954 SCHOOL THERAPY	0	0] 0	0		194. 04
200. 00	507955 VACANT SPACE Cross Foot Adjustments	١	Ü	1	0		194. 05 200. 00
200.00		1	0	_	n		200.00
202.00		348, 090	232, 779	183, 189	0	l .	
						,	· · · · ·

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/29/2024 8:55 pm

Control Cont				1	0 12/31/2023	5/29/2024 8:5	
CEMBRIAL SERVICE CORST BUNDEN CONTROL OF ST OSTS - BUNDEN CONTROL OF ST OSTS - BUNDEN CONTROL OF ST OSTS - BUNDEN CONTROL OF ST OSTS - BUNDEN CONTROL OF ST OSTS - BUNDEN CONTROL OF ST OSTS - BUNDEN CONTROL OF ST OSTS - BUNDEN CONTROL OSTS - BUNDEN CO	Cost Center Description	EMPLOYEE	OTHER	OTHER	OPERATION OF		
DEBERN SERVICE COST CENTERS 1.00 5.01 5.02 7.00 8.00					PLANT	LINEN SERVICE	
SEMERAL SERVICE COST CENTERS IN S. FLYX MULTION 1.00 0.00					7.00	0.00	
1.00	CENEDAL SEDVICE COST CENTEDS	4.00	5.01	5.02	7.00	8.00	
1 01 010 NEW 2016 BULLON R. & FIXT ADDITION							1 00
2 00		•					•
0.000 UPLOYNT IBM IT IS IN PARIMEN 0							•
0.000 0.000 OTHER ABMINISTRATIVE AND CENERAL 0 40, 566 0 0.000		0					ł
5.02 0.0560 OTHER ARMIN ISTRATIVE AND CENERAL 0 11.050 39.957 5.02 5.02 6.05 5.00 6.0		0	40, 565				•
0.00 0.0000 0.00000 0.00000 0.00000 0.00000000		0	11, 500	39, 597			5. 02
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000	7.00 00700 OPERATION OF PLANT	0	3, 240	3, 454	66, 550		7. 00
10.00 0000 DETARY 0 517 551 3,451 0 10.00 13.00	8.00 00800 LAUNDRY & LINEN SERVICE	0	4	4	1, 256	3, 420	8. 00
13.00 01300 MIRSH NR ADMINISTRATION 0 1,819 1,939 413 0 13.00		0					9. 00
14. 00 01400 DENTRAL SERVICES & SUPPLY 0 709 756 0 14. 00	1 1	0		•			•
15.00 01500 PIARDMACY 0 1.894 2.019 193 0 15.00 17		0		1			•
16.00 10-00 MEDICAL RECORDS & LIBRARY 0 10 11 2.940 0 0 0 0 0 0 0 0 0		0				- 1	•
17.00 01700 OSCI AL SERVICE 0 0 0 0 0 0 0 0 0	1 I	0	l .	1			1
19. 00 01900 NON-HYSICI AN ANIESTHETISTS 0 0 0 0 0 19. 00	1 1	0		1	2, 940		1
MARTI ENT ROUTINE SERVICE COST CENTERS	1 1	-	_	1	0		1
30.00		0	0	<u>, </u>	0	0	19.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 41.00 04100 04500 SUBPROVID IBER 0 0 0 0 0 0 0 0 0		1 0	3 411	3 637	19 693	1 050	30.00
ALL DO ALTOO SUBPROVIDER - I RF				1	0		ł
ACCORDING QUARTIC QU		-		o o	0		1
50.00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0		•
1.00	ANCILLARY SERVICE COST CENTERS						
154 00 05400 RADIOLOGY - DIAGNOSTIC 0 2, 244 2, 393 4, 535 436 54. 00 58. 00 05800 RI 0 0 0 0 0 0 0 0 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	50. 00 05000 OPERATING ROOM	0	1, 842	1, 964	17, 140	403	50.00
1.5 1.5		0	791			0	53. 00
SB. 00 OSBOO MRI OSBOO		0	2, 244	2, 393	4, 535		•
99.00 059000 CARDID AC CATHETERIZATION 0 0 0 0 0 0 0 0 0		0	0	0	0		•
60 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0		ı
60.01 60.01 60.00 60.00 0 0 0 0 0 0 0 0 0		0	0	0	0		•
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0		0	2, 987	3, 184	1, 553		1
65.00 0.65		0	0		0		•
66.00 06600 PHYSICAL THERAPY 0 1,114 1,188 3,001 117 66.00 67.00 06700 0CCUPATIONAL THERAPY 0 296 316 3,013 0,07 0.068.00 68.00 06800 SPEECH PATHOLOGY 0 52 55 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 477 5009 582 47 69.00 69.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0 395 421 0 0 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 296 315 0 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 0 0 88.01 08800 RUBAL HEALTH CLINIC 0 0 0 6, 542 0 0 0 88.00 88.01 08800 RUBAL HEALTH CLINIC 0 0 585 664 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 585 664 0 0 0 88.00 99.00 09900 CLINIC CHC) 0 585 664 0 0 0 0 0 0 0 90.00 09000 CLINIC CHC) 0 4,456 4,750 5,736 1,333 91.00 99.10 09100 DEMERGENCY 0 4,456 4,750 5,736 1,333 91.00 99.10 09100 DEMERGENCY 0 0 0 0 0 0 0 0 99.10 09100 DEMERGENCY 0 0 0 0 0 0 0 0 111.00 1100 1100 SLEFT ACQUISITION 0 0 0 0 0 0 0 111.00 113.00 1100 1100 SLEFT ACQUISITION 0 0 0 0 0 0 0 111.00 113.00 1100 0 0 0 0 0 0 0		0	241	1	202		•
67. 00 06700 0CCUPATIONAL THERAPY 0 296 316 3,013 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0.52 5.55 0 0 0.8 69. 00 06900 SPECH PATHOLOGY 0 0.477 5.09 5.82 47 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 395 421 0 0.71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0.73. 00 001747 IMPL. DEV. CHARGED TO PATIENTS 0 817 871 0 0 0 0 0 88. 01 00188.01 O8800 RURAL HEALTH CLINIC II 0 0 0 0 0 0 0 0	1	0					1
68.00 06800 SPEECH PATHOLOGY 0 52 55 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 477 5099 582 47 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 395 421 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENT 0 296 315 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 0 88.00 08800 RURAL HEALTH CLINI C 0 0 0 6.542 0 0 0 88.00 88.01 08800 RURAL HEALTH CLINI C 1 0 0 0 2.068 0 0 88.00 88.02 08802 RURAL HEALTH CLINI C 11 0 0 0 2.068 0 0 0 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89.00 99.00 09900 CLINI C 0 0 2.775 293 0 34 90.00 99.00 09900 CLINI C 0 0 0 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 0 0 0 0 111.00 11000 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 0 111.00 111.00 11100 INTESTINAL ACQUISITION 0 0 0 0 0 0 0 0 111.00 11000 GET EXPENSE 113.00 11000 11000 0 0 0 0 0							•
69.00 06900 ELECTROCARDIOLOGY 0 477 509 582 47 69, 00			l .	1	· ·		•
771.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 395 421 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 296 315 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 007300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 007300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 007300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 73.00 007300 DRUGS CHARGED TO PATIENTS 0 817 871 0 0 88.00 88.01 08800 RURAL HEALTH CLINIC 0 0 0 0 5.542 0 0 88.01 88.02 08800 RURAL HEALTH CLINIC 1 0 0 0 0 0 0 88.01 88.01 08800 RURAL HEALTH CLINIC (RHC) 0 585 624 0 0 0 89.00 99.00 09800 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89.00 99.00 09900 DESERVATION BEDS (NON-DISTINCT PART 0 0 275 293 0 34 90.00 99.10 099100 EMERGENCY 0 4,456 4,750 5,736 1,333 91.00 99.10 09910 CORF 0 0 0 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 0 0 110.00 110.00 110.00 110.00 111.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 111.00 110.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 100.00 0 0 0 0 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 110.00 110.00 110.00 111.00 1	1 1	0		•			•
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 296 315 0 0 72.00	· · · · · · · · · · · · · · · · · · ·	0			0		•
DUTPATI LENT SERVICE COST CENTERS		0	296	315	0	0	72. 00
88 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	817	871	0	0	73.00
88 01 08801 RURAL HEALTH CLINIC (INC)	OUTPATIENT SERVICE COST CENTERS						
88 02 08802 RURAL HEALTH CLINIC (RHC) 0 5855 624 0 0 0 88 02 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89 00 90 00 09000 CLINIC 0 275 293 0 34 90 0 91 00 09000 CLINIC 0 4, 456 4, 750 5, 736 1, 333 91 00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 91 00 095ERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							1
89.00 8900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	0	_		0		1
90. 00 09000 CLINIC 0 275 293 0 34 90. 00 91. 00 09100 EMERGENCY 0 4,456 4,750 5,736 1,333 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 09100 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 99. 10 SPECI AL PURPOSE COST CENTERS 99. 10 10. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 110. 00 11000 INTESTI NAL ACQUISITION 0 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 118. 00 1300 INTEREST EXPENSE 113. 00 119. 00 19000 GIFT FLOWER COST CENTERS 113. 00 119. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CIANS PRI VATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 194. 01 194. 00 07950 TOWN & COUNTRY RHC BLD 0 0 0 0 0 194. 01 194. 02 07952 RENTAL PROPERTIES 0 0 0 0 0 194. 01 194. 03 07955 EDUCATI ON 0 0 0 0 0 194. 03 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 03 200. 00 Nopative Cost Centers 0 0 0 0 0 0 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 201. 00 Nopative Cost Centers 0 0 0 0 0 0 201. 00 Nopative Cost Centers 0 0 0 0 0 201. 00 Nopative Cost Centers 0 0 0 0 0 201. 00 Nopative Cost Centers 0 0 0 0 0 201. 00 Nopative Cost Centers 0 0 0 0 0 201. 00 Nopative Cost Centers 0 0 0 0 0 201. 00 Nopative Cost Centers 0 0 0 0 0 201. 00 Nopative Cost Centers 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 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	585	1	0		ł
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92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0		0					
OTHER REIMBURSABLE COST CENTERS O		0	4, 456	4, 750	5, /36	1, 333	
99. 10 09910 CORF 0							92.00
SPECIAL PURPOSE COST CENTERS 109, 00 109900 PANCREAS ACQUI SITION 0 0 0 0 0 0 0 0 109.00 100		1			0	0	99 10
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109. 00 110			<u> </u>	,	0		77. 10
110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 110.00 111.00 11100 ISLET ACQUI SI TI ON 0 0 0 0 0 0 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) 0 40,565 39,597 66,550 3,420 118.00 NONREI MBURSABLE COST CENTERS		0	0	0	0	0	109 00
111. 00 11100 11					_		
113. 00 11300 11300 1NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 0 40, 565 39, 597 66, 550 3, 420 118. 00 NONREI MBURSABLE COST CENTERS				0	0		1
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 07950 TOWN & COUNTRY RHC BLD 0 0 0 0 0 194.00 194.01 07951 WOODFORD PUBLIC HEALTH 0 0 0 0 0 194.01 194.02 07952 RENTAL PROPERTIES 0 0 0 0 0 194.02 194.03 07953 EDUCATI ON 0 0 0 0 0 194.03 194.04 07954 SCHOOL THERAPY 0 0 0 0 0 194.04 194.05 07955 VACANT SPACE 0 0 0 0 0 194.05 200.00 Negati ve Cost Centers 0 0 0 0 0 201.00 194.04 07954 Cross Foot Adjustments 0 0 0 0 0 194.05 07955 VACANT SPACE 0 0 0 0 0 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00 194.06 07954 07955 0	113.00 11300 I NTEREST EXPENSE						113. 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 0 0 191. 00 191. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 TOWN & COUNTRY RHC BLD 0 0 0 0 0 0 194. 00 194. 01 07951 WOODFORD PUBLI C HEALTH 0 0 0 0 0 0 194. 01 194. 02 07952 RENTAL PROPERTI ES 0 0 0 0 0 0 194. 02 194. 03 07953 EDUCATI ON 0 0 0 0 0 194. 03 194. 04 07954 SCHOOL THERAPY 0 0 0 0 0 0 194. 03 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 07055 VACANT SPACE 0 0 0 0 0 0 0 194. 05 07055 VACANT SPACE 0 0 0 0 0 0 0 0 0 194. 05 07055 VACANT SPACE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	40, 565	39, 597	66, 550	3, 420	118. 00
191. 00 19100 RESEARCH	NONREI MBURSABLE COST CENTERS						
192. 00 19200 19200 19200 19300 19300 19300 19300 19300 19300 19300 194. 00 194. 00 194. 00 194. 00 194. 01 194. 01 194. 02 194. 03 19730 194. 04 19730 194. 04 19730 194. 05 19730 194. 05 19730 194. 05 19730 194. 05 19730 194. 05 19730 194. 05 19730 194. 05 19730 194. 05 19730	190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 194. 00 194. 00 194. 01 194. 01 194. 02 194. 03 194. 04 194. 04 194. 04 194. 05 194. 05 194. 05 196. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0		
194. 00 07950 TOWN & COUNTRY RHC BLD 0 0 0 0 194. 00 194. 01 07951 WOODFORD PUBLIC HEALTH 0 0 0 0 0 194. 02 07952 RENTAL PROPERTIES 0 0 0 0 194. 03 07953 EDUCATION 0 0 0 194. 04 07954 SCHOOL THERAPY 0 0 0 194. 05 07955 VACANT SPACE 0 0 0 200. 00 Cross Foot Adjustments 0 0 0 201. 00 Negative Cost Centers 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 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 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 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 201. 00 0 201. 00 201. 00 0 201. 00		0	0	0	0		
194. 01 07951 WOODFORD PUBLIC HEALTH 0 0 0 0 0 0 194. 01 194. 02 07952 RENTAL PROPERTIES 0 0 0 0 0 0 194. 02 194. 03 07953 EDUCATION 0 0 0 0 0 194. 03 194. 04 07954 SCHOOL THERAPY 0 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 05 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0		
194. 02 07952 RENTAL PROPERTIES 0 0 0 0 0 194. 02 194. 03 07953 EDUCATION 0 0 0 0 194. 03 194. 04 07954 SCHOOL THERAPY 0 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00		0	0	0	0		
194. 03 07953 EDUCATION 0 0 0 0 194. 03 194. 04 07954 SCHOOL THERAPY 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00		0	0	0	0		
194. 04 07954 SCHOOL THERAPY 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00		0		0	0		1
194. 05 07955 VACANT SPACE 0 0 0 0 194. 05 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00					0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00							
201.00 Negative Cost Centers 0 0 0 0 201.00				,			
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				39. 597	66. 550		
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| 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: 14-1309

				To	12/31/2023	Date/Time Pre 5/29/2024 8:5	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	J
		9. 00	10.00	13. 00	14.00	15. 00	
1 00	GENERAL SERVICE COST CENTERS			1			1 00
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 NEW 2016 BUILDING & FIXT ADDITION						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING	7, 041					9. 00
10.00	01000 DI ETARY	152	11, 361				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	4, 972	4 (00		13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	164	0	0	1, 629	4, 106	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		0		0	4, 100	1
17. 00	01700 SOCIAL SERVICE	o	0	o	o	0	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 ((2)	11 2/1	2.0(/	٥		20.00
30. 00 33. 00	03000 ADULTS & PEDIATRICS 03300 BURN INTENSIVE CARE UNIT	1, 662	11, 361 0	2, 066	0	0	
41. 00	04100 SUBPROVI DER - I RF		0	1	o	0	1
42. 00	04200 SUBPROVI DER	0	0	0	0	0	1
	ANCILLARY SERVICE COST CENTERS				-1	_	4
50.00	05000 OPERATING ROOM	1, 014	0		0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	509	0	0	0	0	53. 00 54. 00
57. 00	05700 CT SCAN	0	0	Ö	Ö	0	1
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	232	0	0	0	0	
64. 00	06400 I NTRAVENOUS THERAPY		0	1	0	0	1
65. 00	06500 RESPI RATORY THERAPY	242	0	O	o	0	1
66. 00	06600 PHYSI CAL THERAPY	542	0	0	0	0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	44	0	231	0	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	l o	0	1	929	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	О	700	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	4, 106	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	O	0	O	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0		o	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	_0	0	0	
90.00	09000 CLI NI C 09100 EMERGENCY	607	0	77	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 873	0	1, 751	O	0	91.00
	OTHER REIMBURSABLE COST CENTERS						1
99. 10	09910 CORF	0	0	0	0	0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	O	0	O	0		109. 00
	11000 NTESTINAL ACQUISITION		0	1	0		1109.00
	11100 SLET ACQUISITION	l o	0	Ö	Ö		111. 00
	11300 I NTEREST EXPENSE						113. 00
118.00		7, 041	11, 361	4, 972	1, 629	4, 106	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	O	0		190. 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	-	0		191. 00
	19200 PHYSICIANS PRIVATE OFFICES	o	0	O	o		192. 00
	19300 NONPALD WORKERS	0	0	0	o		193. 00
	07950 TOWN & COUNTRY RHC BLD	0	0	0	0		194. 00
	07951 WOODFORD PUBLIC HEALTH 07952 RENTAL PROPERTIES		0		0		194. 01 194. 02
	07953 EDUCATI ON		0	l ol	ol		194. 02
194.04	07954 SCHOOL THERAPY	0	0	o	o		194. 04
	07955 VACANT SPACE	0	0	이	0	0	194. 05
200. 00 201. 00	1 1		0			Ō	200. 00 201. 00
202.00		7, 041	11, 361	4, 972	1, 629		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 od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1309

			'	0 12/31/2023	Date/lime Pre 5/29/2024 8:5	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown	Э рин
	16. 00	17. 00	19. 00	24. 00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS	10.00	17.00	19.00	24.00	25.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW 2016 BUILDING & FIXT ADDITION 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00590 OTHER ADMINISTRATIVE AND GENERAL 5.02 00560 OTHER ADMINISTRATIVE AND GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE	17, 927 0	0				1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0			19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	17, 927	0		146, 589	0	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0	Ö	33.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0		0	0	42. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	0	0		100, 809	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		4, 611	Ö	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		128, 560	0	54. 00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	0		0	0	57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	58. 00 59. 00
60. 00 06000 LABORATORY	0	0		10, 966	Ö	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		1, 610 11, 781	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		8, 050	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		5, 949	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		3, 019	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		3, 435 1, 311	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		5, 794	0	73.00
OUTPATIENT SERVICE COST CENTERS				27.1.1		
88. 00 08800 RURAL HEALTH CLINIC	0	0		257, 616	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	0		40, 443	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC (RHC) 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		1, 209	0	88. 02 89. 00
90. 00 09000 CLI NI C	Ö	0		1, 286		90.00
91. 00 09100 EMERGENCY	0	0		31, 020		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92. 00
99. 10 09910 CORF	0	0		0	0	99. 10
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	I.	<u> </u>		77.10
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111.00 11100 ISLET ACQUISITION 113.00 11300 INTEREST EXPENSE	0	0		U	U	111. 00 113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 927	0	О	764, 058	0	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0		190. 00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		0		191. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
194.00 07950 TOWN & COUNTRY RHC BLD	0	0		0		194. 00
194. 01 07951 WOODFORD PUBLIC HEALTH	0	0		0		194. 01
194. 02 07952 RENTAL PROPERTI ES 194. 03 07953 EDUCATI ON	0	0		0		194. 02 194. 03
194. 04 07953 EDUCATION 194. 04 07954 SCHOOL THERAPY		0		0		194. 03
194. 05 07955 VACANT SPACE		o		o o	0	194. 05
200.00 Cross Foot Adjustments			0	0	0	200. 00
201.00 Negative Cost Centers	17 007	0	0	744 050		201. 00
202.00 TOTAL (sum lines 118 through 201)	17, 927	0	0	764, 058	ı ⁰	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS CARLE EUREKA HOSPITAL

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II |
| To | 12/31/2023 | Date/Time | Prepared: | 5/29/2024 8:55 pm | Provider CCN: 14-1309

		5/29/2024 8:55 pm
Cost Center Description	Total	
GENERAL SERVI CE COST CENTERS	26. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT		1.0
1. 01 00101 CAF REE COSTS=BEDG & TTXT		1.0
2. 00 00200 CAP REL COSTS-MVBLE EQUIP		2.0
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT		4.0
5.01 00590 OTHER ADMINISTRATIVE AND GENERAL		5. 0
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL		5. C
7.00 O0700 OPERATION OF PLANT		7.0
8.00 00800 LAUNDRY & LINEN SERVICE		8.0
9. 00 00900 HOUSEKEEPI NG		9.0
10. 00 01000 DI ETARY		10.0
13. 00 01300 NURSI NG ADMI NI STRATI ON		13. 0
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY		14. C 15. C
16. 00 01600 MEDI CAL RECORDS & LI BRARY		16. 0
17. 00 01700 SOCIAL SERVICE		17. 0
19. 00 01900 NONPHYSI CLAN ANESTHETI STS		19.0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		
30. 00 03000 ADULTS & PEDI ATRI CS	146, 589	30.0
33.00 03300 BURN INTENSIVE CARE UNIT	o	33.0
41. 00 04100 SUBPROVI DER - I RF	0	41.0
42. 00 04200 SUBPROVI DER	0	42. 0
ANCILLARY SERVICE COST CENTERS		
50. 00 05000 OPERATI NG ROOM	100, 809	50.0
53. 00 05300 ANESTHESI OLOGY	4, 611	53. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	128, 560	54. 0
57. 00 05700 CT SCAN	0	57. 0
58. 00 05800 MRI	0	58. 0
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	10, 966	59. C
60. 01 06001 BLOOD LABORATORY	10, 400	60.0
64. 00 06400 I NTRAVENOUS THERAPY	o	64.0
65. 00 06500 RESPIRATORY THERAPY	1, 610	65.0
66. 00 06600 PHYSI CAL THERAPY	11, 781	66.0
67. 00 06700 OCCUPATI ONAL THERAPY	8, 050	67. 0
68.00 06800 SPEECH PATHOLOGY	5, 949	68.0
69. 00 06900 ELECTROCARDI OLOGY	3, 019	69.0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 435	71. 0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 311	72. 0
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	5, 794	73. 0
88. 00 08800 RURAL HEALTH CLINIC	257, 616	88. 0
88. 01 08801 RURAL HEALTH CLINIC II	40, 443	88. 0
88. 02 08802 RURAL HEALTH CLINIC (RHC)	1, 209	88.0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.0
90. 00 09000 CLI NI C	1, 286	90.0
91. 00 09100 EMERGENCY	31, 020	91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		92. 0
OTHER REIMBURSABLE COST CENTERS 99. 10 O9910 CORF	O	99. 1
SPECIAL PURPOSE COST CENTERS	U	99. 1
109. 00 10900 PANCREAS ACQUISITION	0	109. 0
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	ő	110.0
111. 00 11100 SLET ACQUI SI TI ON	o	111.0
113.00 11300 I NTEREST EXPENSE		113. 0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	764, 058	118. C
NONREI MBURSABLE COST CENTERS		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	190. 0
191. 00 19100 RESEARCH	0	191. C
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	192. 0
193. 00 19300 NONPALD WORKERS	0	193. 0
194.00 07950 TOWN & COUNTRY RHC BLD	0	194. 0
194. 01 07951 WOODFORD PUBLIC HEALTH 194. 02 07952 RENTAL PROPERTIES	0	194. C 194. C
194. 02 07952 RENTAL PROPERTIES 194. 03 07953 EDUCATION	0	194. (
194. 04 07953 EDUCATION 194. 04 07954 SCHOOL THERAPY	0	194. (
194. 04 07954 SCHOOL THEKAPT 194. 05 07955 VACANT SPACE	0	194. 0
200.00 Cross Foot Adjustments	0	200. 0
201.00 Negative Cost Centers	o	201. 0
202.00 TOTAL (sum lines 118 through 201)	764, 058	202. 0

					To 12/31/2023		
		CAP	ITAL RELATED CO	OSTS		5/29/2024 8:5	5 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT	Reconciliation	
			(NEW BUILDI NG SQUARE)		(GROSS SALARI ES)		
		1. 00	1. 01	2.00	4. 00	5A. 01	
	GENERAL SERVICE COST CENTERS						
1.00	OO100 CAP REL COSTS-BLDG & FIXT OO101 NEW 2016 BUILDING & FIXT ADDITION	70, 288	1	,			1.00
1. 01 2. 00	00200 CAP REL COSTS-MVBLE EQUIP		21, 452)		1. 01 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	1	13, 698, 274		4. 00
5. 01	00590 OTHER ADMINISTRATIVE AND GENERAL	12, 248	1	1	351, 275		5. 01
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	7, 311		1	407, 621	l .	5. 02
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	8, 590 651	1		304, 580	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	1, 024	ł		179, 277		9.00
10.00	01000 DI ETARY	2, 020	1) (0	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	242	l		328, 922	l .	13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	1		41, 609 265, 405	l .	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 721	1		0	ő	16.00
17. 00	01700 SOCIAL SERVICE	0	0) (0	0	17. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0) (0	0	19. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 916	8, 420		1, 303, 360	0	30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	2, 710	1	1	0 1, 303, 300	ő	33. 00
41. 00	04100 SUBPROVI DER - I RF	0	0		0		41. 00
42. 00	04200 SUBPROVI DER	0	0) (0	0	42. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1, 547	8, 487	' (634, 527	0	50.00
53. 00	05300 ANESTHESI OLOGY	593					53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 403	252	2	690, 318		54. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0				0	58. 00 59. 00
60. 00	06000 LABORATORY	909	1		705, 258		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	165 1, 757	ł		87, 185 497, 616		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 336	ł		123, 256		67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 764	. 0		18, 600	l .	68. 00
69. 00	06900 ELECTROCARDI OLOGY	341	0		229, 580	l .	69.00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	103	l	1		0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			o o	Ö	73. 00
	OUTPATIENT SERVICE COST CENTERS					I	
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	10, 375 8, 914	l		2, 647, 996 772, 987		1
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0, 714	1		235, 157		88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) (0	0	89. 00
90.00	09000 CLINIC	0	0		112, 589		90.00
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	3, 358			3, 182, 197	0	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	1	1	1			72.00
99. 10	09910 CORF	0	0) (0	0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION			\	0		109. 00
	11000 NTESTINAL ACQUISITION						1109.00
	11100 SLET ACQUISITION	0			o o		111.00
	11300 I NTEREST EXPENSE						113. 00
118. 00		70, 288	21, 452	2 (13, 698, 274	-5, 488, 109	118. 00
190.00	NONREI MBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN) 0	0	190. 00
	19100 RESEARCH	0	o		Ö		191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0		0		192.00
	19300 NONPALD WORKERS 07950 TOWN & COUNTRY RHC BLD	0			0		193. 00 194. 00
	07950 TOWN & COUNTRY RAC BED	1 0			0		194. 00
194. 02	07952 RENTAL PROPERTIES		0		o o	0	194. 02
	07953 EDUCATION	0	0		0		194. 03
	07954 SCHOOL THERAPY 07955 VACANT SPACE				0		194. 04 194. 05
200.00				1	1		200.00
201.00		1		1			201. 00

Heal th Finar	ncial Systems	CARLE EUREKA	A HOSPITAL		In Li€	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023		
		CAPI	TAL RELATED CO)STS			
	Cost Center Description	BLDG & FIXT	NEW 2016	MVBLE EQUIP		Reconciliation	
		(SQUARE FEET)	BUI LDI NG &	(DOLLAR VALUE	'		
			FIXT ADDITION		DEPARTMENT		
			(NEW BUILDI NG SQUARE)		(GROSS SALARI ES)		
		1.00	1. 01	2.00	4. 00	5A. 01	
202.00	Cost to be allocated (per Wkst. B,	232, 779	183, 189		0 405, 720		202. 00
000 00	Part I)	0.044700	0 500400		0.000/40		000 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	3. 311789	8. 539483	0. 00000	0. 029618		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)				0		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1309

				Ť	0 12/31/2023	Date/Time Prep 5/29/2024 8:59	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	Reconciliation	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	y pin
		(ACCUM. COST)		(ACCUM. COST)	,	LAUNDRY)	
	GENERAL SERVICE COST CENTERS	5. 01	5A. 02	5. 02	7. 00	8. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 NEW 2016 BUILDING & FIXT ADDITION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00590 OTHER ADMINISTRATIVE AND GENERAL 00560 OTHER ADMINISTRATIVE AND GENERAL	23, 192, 834	4 770 474	21 001 247			5. 01 5. 02
5. 02 7. 00	00700 OPERATION OF PLANT	6, 574, 219 1, 852, 639	-6, 779, 676 0	21, 901, 267 1, 910, 540			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 156	0	2, 223		34, 488	8. 00
9.00	00900 HOUSEKEEPI NG	327, 768	0	338, 012		0	9. 00
10. 00	01000 DI ETARY	295, 693	0	304, 934		0	10. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 040, 170	0	1, 072, 678		0	13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	405, 610	0	418, 287		0	14.00
15. 00 16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 082, 694 5, 700	0	1, 116, 531 5, 878		0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	3, 700	0	3, 0, 0	0	Ö	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	o	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			,			
30.00	03000 ADULTS & PEDIATRICS	1, 950, 512	0	2, 011, 471	11, 528		30. 00
33. 00 41. 00	03300 BURN INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0 0	0	0	0	0	33. 00 41. 00
42.00	04200 SUBPROVI DER		0	0	0	0	41.00
42.00	ANCI LLARY SERVI CE COST CENTERS	٩					72.00
50.00	05000 OPERATING ROOM	1, 053, 241	0	1, 086, 158	10, 034	4, 068	50.00
53.00	05300 ANESTHESI OLOGY	452, 051	0	,		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 283, 241	0	1, 323, 346	2, 655	· ·	54.00
57. 00	05700 CT SCAN 05800 MRI	0	0	0	0	0	57.00
58. 00 59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	58. 00 59. 00
60. 00	06000 LABORATORY	1, 707, 854	0	1, 761, 230	909	Ö	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	149, 485	0	154, 157		0	65. 00
66. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	637, 073	0	656, 983		1, 183	66.00
67. 00 68. 00	06800 SPEECH PATHOLOGY	169, 425 29, 718	0	174, 720 30, 647		0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	272, 821	0	281, 347		472	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	225, 678	0	232, 731		0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	169, 033	0			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	466, 943	0	481, 536	0	0	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	l ol	0	3, 619, 421	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0	1, 143, 850	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	334, 576	0	345, 033		0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0	0	0	0	89. 00
	09000 CLI NI C	157, 059	0				90.00
91.00	09100 EMERGENCY	2, 547, 475	0	2, 627, 091	3, 358	13, 442	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
99. 10	09910 CORF	O	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	-1				-	
109.00	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	11100 SLET ACQUI SITI ON	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	23, 192, 834	-6, 779, 676	21, 901, 267	38, 959	34, 488	113.00
110.00	NONREI MBURSABLE COST CENTERS	25, 172, 054	0, 117, 010	21, 701, 207	30, 737	34, 400	1110.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00 194. 00
	07950 TOWN & COUNTRY RHC BLD 07951 WOODFORD PUBLIC HEALTH		0	0	0		194. 00
	207952 RENTAL PROPERTIES		0	0	0		194. 02
194. 03	07953 EDUCATI ON		0	Ö	Ö		194. 03
194. 04	07954 SCHOOL THERAPY	0	0	0	0		194. 04
	07955 VACANT SPACE	0	0	0	0		194. 05
200.00	, ,						200.00
201. 00 202. 00		724, 838		6, 779, 676	2, 501, 959		201.00
∠∪∠. ∪(Part I)	124,038		0, 119, 010	2, 501, 959	50, 113	202.00
203.00	1 1 1	0. 031253		0. 309556	64. 220309	1. 453056	203. 00
					<u> </u>	·	

Health Fina	ancial Systems	CARLE EUREKA	A HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/29/2024 8:5	
	Cost Center Description	OTHER	Reconciliation	OTHER	OPERATION OF	LAUNDRY &	
		ADMI NI STRATI VE		ADMI NI STRATI V	PLANT	LINEN SERVICE	
		AND GENERAL		AND GENERAL	(SQUARE FEET)	(POUNDS OF	
		(ACCUM. COST)		(ACCUM. COST)		LAUNDRY)	
		5. 01	5A. 02	5. 02	7. 00	8. 00	
204.00	Cost to be allocated (per Wkst. B,	40, 565		39, 59	66, 550	3, 420	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 001749		0. 00180	1. 708206	0. 099165	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
		,		•			

COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/29/2024 8:5	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	J
		(HOURS OF SERVICE)	(HOURS OF SERVICE)	ADMI NI STRATI ON	SERVI CES & SUPPLY	(COSTED REQ ULSI)	
			ŕ	(HOURS OF	(COSTED REQ	ŕ	
		9.00	10. 00	SERVI CE) 13. 00	UI SI) 14. 00	15. 00	
	RAL SERVICE COST CENTERS						
1	O CAP REL COSTS-BLDG & FIXT 1 NEW 2016 BUILDING & FIXT ADDITION						1.00
2.00 0020	O CAP REL COSTS-MVBLE EQUIP						2. 00
1	O EMPLOYEE BENEFITS DEPARTMENT O OTHER ADMINISTRATIVE AND GENERAL						4. 00 5. 01
	O OTHER ADMINISTRATIVE AND GENERAL						5. 02
	O OPERATION OF PLANT						7. 00
1	O LAUNDRY & LINEN SERVICE O HOUSEKEEPING	4, 949					8. 00 9. 00
	O DI ETARY	107	100				10.00
	O NURSI NG ADMI NI STRATI ON	0	0	42, 251	202 222		13.00
	O CENTRAL SERVICES & SUPPLY O PHARMACY	115	0	0	393, 323 0	466, 658	14. 00 15. 00
	MEDICAL RECORDS & LIBRARY	O	0	0	0	0	16. 00
	O SOCIAL SERVICE O NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	TIENT ROUTINE SERVICE COST CENTERS	0	0		U U	0	17.00
	O ADULTS & PEDIATRICS	1, 168	100			0	
	O BURN INTENSIVE CARE UNIT O SUBPROVIDER - IRF	0	0	0	1	0	
	O SUBPROVI DER	Ö	0	Ö	1		1
	LLARY SERVICE COST CENTERS	712	0	7 100		0	 FO 00
	O OPERATING ROOM O ANESTHESIOLOGY	713	0	7, 198 0	0	0	
54.00 0540	O RADI OLOGY-DI AGNOSTI C	358	0	0	o	0	0 00
57. 00 05700 58. 00 05800	O CT SCAN	0	0	0	0	0	07.00
	CARDIAC CATHETERIZATION		0	Ö	0	0	59.00
	O LABORATORY	163	0	0	0	0	60.00
1	1 BLOOD LABORATORY O I NTRAVENOUS THERAPY	0	0		0	0	60.01
65. 00 0650	RESPI RATORY THERAPY	170	0	0	o	0	65. 00
	O PHYSICAL THERAPY O OCCUPATIONAL THERAPY	381	0	0	0	0	66. 00 67. 00
	O SPEECH PATHOLOGY		0	Ö	0	0	68. 00
	O ELECTROCARDI OLOGY	31	0	1, 965		0	69.00
	OMEDICAL SUPPLIES CHARGED TO PATIENT OIMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	71. 00 72. 00
73. 00 0730	D DRUGS CHARGED TO PATIENTS	ō	0	0		466, 658	1
	ATIENT SERVICE COST CENTERS ORURAL HEALTH CLINIC	O	0	0	ol	0	88. 00
	1 RURAL HEALTH CLINIC II		0	0			
88. 02 0880	2 RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	
	O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC	0 427	0	652	0	0	07.00
91.00 0910	O EMERGENCY	1, 316	0	14, 882		Ö	1
	O OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS						92. 00
99. 10 0991		0	0	0	0	0	99. 10
	AL PURPOSE COST CENTERS			1			
	O PANCREAS ACQUISITION O INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
111. 00 1110	O ISLET ACQUISITION	Ö	0	Ö	o		111. 00
113. 00 1130 118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 949	100	42, 247	393, 293	466, 658	113.00
	EIMBURSABLE COST CENTERS	4, 747	100	42, 247	373, 273	400, 038	1118.00
	O GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 1910 192. 00 1920	O RESEARCH O PHYSICIANS PRIVATE OFFICES		0	0	0		191. 00 192. 00
193. 00 1930	NONPALD WORKERS	ō	0	0	O	0	193. 00
	O TOWN & COUNTRY RHC BLD 1 WOODFORD PUBLIC HEALTH	0	0	0	0		194. 00 194. 01
	2 RENTAL PROPERTIES		0		ol		194. 01
194. 03 0795	3 EDUCATI ON	0	0	4	30		194. 03
	4 SCHOOL THERAPY 5 VACANT SPACE	0	0	0	0		194. 04 194. 05
200. 00	Cross Foot Adjustments		O				200. 00
201.00	Negative Cost Centers	F00 400	E40 045	1 420 272	EEO EO4	1 4/0 417	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	508, 408	540, 045	1, 420, 273	559, 584	1, 469, 417	202.00
		· '		•	·	-	-

Heal th Fi	nancial Systems	CARLE EUREKA	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023 Fo 12/31/2023		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
		(HOURS OF		ADMI NI STRATI O		(COSTED REQ	
		SERVICE)	SERVI CE)		SUPPLY	UISI)	
				(HOURS OF	(COSTED REQ		
				SERVICE)	UISI)		
		9. 00	10.00	13.00	14.00	15. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	102. 729440	5, 400. 450000	33. 61513	1. 422709	3. 148809	203. 00
204.00	Cost to be allocated (per Wkst. B,	7, 041	11, 361	4, 97	1, 629	4, 106	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	1. 422712	113. 610000	0. 11767	0. 004142	0. 008799	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

CARLE EUREKA HOSPITAL

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 8:55 pm Provider CCN: 14-1309

					5/29/2024	
	Cost Center Description		SOCIAL SERVICE			
		RECORDS & LI BRARY	(TIME SPENT)	ANESTHETI STS (ASSI GNED		
		(GROSS CHAR	(TIME SELVI)	TIME)		
		GES)		· · ···/		
		16. 00	17. 00	19. 00		
1 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT			I	I	1 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW 2016 BUILDING & FIXT ADDITION					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00590 OTHER ADMINISTRATIVE AND GENERAL					5. 01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL					5. 02
7. 00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY					14. 00
15.00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	200				16. 00
17. 00	01700 SOCI AL SERVI CE	0	0			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	<u> </u>		19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	200	0	1 0	ı	30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0			33. 00
41. 00	04100 SUBPROVI DER - I RF	0	Ö			41.00
42. 00	04200 SUBPROVI DER	0	0			42. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0			50. 00
53. 00	05300 ANESTHESI OLOGY	0	0	1		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C		54. 00 57. 00
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	0			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
60.00	06000 LABORATORY	Ö	Ö	ď		60.00
60. 01	06001 BLOOD LABORATORY	0	0	C		60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0	C		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	C		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	C		66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	0			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	ĺ		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C		73. 00
	OUTPATIENT SERVICE COST CENTERS	_		1	ı	
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	0	C		88. 00 88. 01
	08802 RURAL HEALTH CLINIC (RHC)	0	0			88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1		89. 00
	09000 CLI NI C	0	0	d		90.00
	09100 EMERGENCY	0	0	C		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
00 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0			99. 10
99. 10	SPECIAL PURPOSE COST CENTERS	0	0	1		99. 10
109.00	10900 PANCREAS ACQUISITION	0	0	C		109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	C		110. 00
	11100 I SLET ACQUISITION	0	0	C		111. 00
	11300 I NTEREST EXPENSE		_	_		113. 00
118. 00	, ,	200	0	C		118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		ı	190. 00
	19100 RESEARCH	0	Ö			191.00
	19200 PHYSICIANS PRIVATE OFFICES	0	Ō	d		192. 00
193.00	19300 NONPALD WORKERS	0	0	C		193. 00
	07950 TOWN & COUNTRY RHC BLD	0	0	C		194. 00
	07951 WOODFORD PUBLIC HEALTH	0	0	C		194. 01
	07952 RENTAL PROPERTIES	0	0			194. 02
	07953 EDUCATION 07954 SCHOOL THERAPY		0			194. 03 194. 04
	07955 VACANT SPACE	0	0			194. 04
200.00						200.00
201.00						201. 00
202.00	Cost to be allocated (per Wkst. B,	118, 221	0	C		202. 00
	Part I)			l		

Heal th Finan	cial Systems	CARLE EUREKA	A HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2023	Worksheet B-1	
					Fo 12/31/2023	Date/Time Pre 5/29/2024 8:5	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE				
		RECORDS &		ANESTHETI STS			
		LI BRARY	(TIME SPENT)	(ASSI GNED			
		(GROSS CHAR		TIME)			
		GES)					
		16.00	17. 00	19. 00			
203.00	Unit cost multiplier (Wkst. B, Part I)	591. 105000	0. 000000	0.000000			203. 00
204.00	Cost to be allocated (per Wkst. B,	17, 927	0	(204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	89. 635000	0. 000000	0.000000			205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)		l				

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1309	Peri od:	Worksheet C
		From 01/01/2023	

					o 12/31/2023	Date/Time Pre 5/29/2024 8:5	pared:
			Title	XVIII	Hospi tal	Cost	<u> Э</u> Рііі
			11110	XVIII	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost contor bescriptron	(from Wkst. B,	Adj .	l lotal costs	Di sal I owance	10101 00313	
		Part I, col.	7.00		Di Gai i Gilano		
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 758, 051		4, 758, 051	0	0	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		C	o	0	33. 00
41.00	04100 SUBPROVI DER - I RF	0		l c	o	0	41. 00
42.00	04200 SUBPROVI DER	0		l c	o	0	42. 00
A	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 387, 891		2, 387, 891	0	0	50. 00
53.00	D5300 ANESTHESI OLOGY	648, 571		648, 571	o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 946, 664		1, 946, 664	. 0	0	54.00
57.00	D5700 CT SCAN	0		C	o	0	57.00
58. 00 0	05800 MRI	0		C	o	0	58. 00
59.00	05900 CARDIAC CATHETERIZATION	0		C	o	0	59. 00
60.00	06000 LABORATORY	2, 381, 550		2, 381, 550	0	0	60.00
60. 01 0	06001 BLOOD LABORATORY	0		C	0	0	60. 01
64.00	06400 INTRAVENOUS THERAPY	0		C	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	229, 937	0	229, 937	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 014, 050	0	1, 014, 050	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	342, 091	0	342, 091	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	40, 134	0	40, 134	. 0	0	68. 00
69.00	D6900 ELECTROCARDI OLOGY	460, 264		460, 264	. 0	0	69. 00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	623, 830		623, 830	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	468, 762		468, 762	0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	2, 100, 015		2, 100, 015	0	0	73. 00
	DUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	4, 739, 840		4, 739, 840	0	0	
	D8801 RURAL HEALTH CLINIC II	1, 497, 936		1, 497, 936		0	88. 01
	08802 RURAL HEALTH CLINIC (RHC)	451, 840		451, 840	0	0	88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
	09000 CLI NI C	278, 381		278, 381	1	0	90.00
	09100 EMERGENCY	4, 310, 959		4, 310, 959		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	319, 061		319, 061		0	92. 00
	OTHER REIMBURSABLE COST CENTERS			T	, , , , , , , , , , , , , , , , , , , ,		
	09910 CORF	0		C		0	99. 10
	SPECIAL PURPOSE COST CENTERS	T		T	1		
	10900 PANCREAS ACQUISITION	0		C			109. 00
	11000 INTESTINAL ACQUISITION	0		C)		110. 00
	11100 SLET ACQUISITION	0		C		0	111. 00
	11300 I NTEREST EXPENSE		_		_	_	113. 00
200.00	Subtotal (see instructions)	28, 999, 827	0				200. 00
201.00	Less Observation Beds	319, 061	_	319, 061			201. 00
202. 00	Total (see instructions)	28, 680, 766	0	28, 680, 766	0	0	202. 00

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1309	Period: Worksheet C From 01/01/2023 Part I

					-rom 01/01/2023 Го 12/31/2023	Part I Date/Time Pre 5/29/2024 8:5	
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6		TEFRA	
				+ col. 7)	Ratio	Inpati ent	
			7.00	0.00	0.00	Rati o	
	INDATIONE DOUTING CODY OF COCT CONTEDC	6. 00	7. 00	8. 00	9. 00	10.00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1 005 000		1 005 00	a		20.00
33. 00	i i	1, 925, 833		1, 925, 83			30.00
41. 00	03300 BURN INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0					33.00
41.00	04200 SUBPROVI DER	0					41. 00 42. 00
42.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>)		42.00
50. 00	05000 OPERATING ROOM	12, 265	1, 100, 788	1, 113, 05	2. 145352	0. 000000	50.00
53. 00	05300 ANESTHESI OLOGY	19, 594	618, 372	637, 96		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	997, 137	11, 306, 229			0. 000000	
57. 00	05700 CT SCAN	777, 137	11, 300, 227	12, 303, 30	0. 000000	0. 000000	
58. 00	05800 MRI		0		0.000000	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	· ·	0.000000	0. 000000	
60.00	06000 LABORATORY	828, 265	7, 351, 544	8, 179, 80		0. 000000	
60. 01	06001 BLOOD LABORATORY	020,200	0	0, ., ,, 00	0.000000	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	o	0		0. 000000	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	2, 034	754, 377	756, 41		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	304, 923	1, 032, 104			0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	52, 561	288, 109	340, 67	1. 004171	0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 110	628	4, 73	8. 470663	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	69, 718	1, 115, 985			0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	42, 543	359, 719	402, 26	1. 550805	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	136, 157	388, 122	524, 27	0. 894108	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 522, 368	2, 759, 099	4, 281, 46	0. 490490	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	6, 187, 188				88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	1, 619, 391	1, 619, 39	1		88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	239, 986	239, 98	5		88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		D		89. 00
90. 00	09000 CLI NI C	1, 151	340, 373			0. 000000	1
91. 00	09100 EMERGENCY	368, 010	6, 368, 706			0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	266, 992	243, 168	510, 16	0. 625414	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0		0		99. 10
400.00	SPECIAL PURPOSE COST CENTERS						100.00
	10900 PANCREAS ACQUISITION	0	0				109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0				110.00
	11100 ISLET ACQUISITION 11300 INTEREST EXPENSE	0	0	'	ا		111.00
	1 1	4 550 441	42 072 000	40 427 54			113. 00 200. 00
200. 00 201. 00	,	6, 553, 661	42, 073, 888	48, 627, 54	7		200.00
201.00	+ I	6, 553, 661	42, 073, 888	48, 627, 54 ⁻			201.00
202.00	Trotal (See Histiactions)	0, 333, 00 1	42,073,000	1 40,027,04	1	l	1202.00

Health Financial Systems CARLE EUREKA HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period:

			To 12/31/2023	Date/Time Prepared: 5/29/2024 8:55 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
LUBATI ENT. DOUTLING OFFICE OF COOT, OFFITEDO	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				20.00
30.00 03000 ADULTS & PEDIATRICS 33.00 03300 BURN INTENSIVE CARE UNIT				30.00
33.00 03300 BURN INTENSIVE CARE UNIT 41.00 04100 SUBPROVI DER - IRF				33. 00 41. 00
41. 00 04100 SUBPROVI DER - 1 RF 42. 00 04200 SUBPROVI DER				42.00
ANCI LLARY SERVI CE COST CENTERS				42.00
50. 00 O5000 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
57. 00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MRI	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
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 (RHC)				88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0.000000			90.00
91. 00 09100 EMERGENCY	0.000000			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 000000			92. 00
99. 10 09910 CORF				99. 10
SPECIAL PURPOSE COST CENTERS				99. 10
109. 00 10900 PANCREAS ACQUISITION				109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100 I SLET ACQUI SI TI ON				111.00
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1			1

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Vorksheet C
		From 01/01/2023 F	

					rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/29/2024 8:5	
			Ti tl	e XIX	Hospi tal	Cost	
	<u> </u>				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.	1				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
-	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 758, 051		4, 758, 051	0	4, 758, 051	30. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0		l c	0	0	33. 00
41.00	04100 SUBPROVI DER - I RF	0		l c	0	0	41.00
42.00	04200 SUBPROVI DER	0		l c	0	0	42.00
	ANCILLARY SERVICE COST CENTERS	1		<u>'</u>			
50.00	05000 OPERATING ROOM	2, 387, 891		2, 387, 891	0	2, 387, 891	50. 00
53.00	05300 ANESTHESI OLOGY	648, 571		648, 571		648, 571	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 946, 664		1, 946, 664	0	1, 946, 664	54.00
57.00	05700 CT SCAN	0			0	0	
58.00	05800 MRI	0		l c	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		l c	0	0	59. 00
60.00	06000 LABORATORY	2, 381, 550		2, 381, 550	0	2, 381, 550	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0	0	1
64. 00	06400 I NTRAVENOUS THERAPY	0		i o	0	0	1
65. 00	06500 RESPI RATORY THERAPY	229, 937	0	229, 937	0	229, 937	1
66. 00	06600 PHYSI CAL THERAPY	1, 014, 050	0	1, 014, 050		1, 014, 050	1
67. 00	06700 OCCUPATI ONAL THERAPY	342, 091	0	342, 091		342, 091	
68. 00	06800 SPEECH PATHOLOGY	40, 134	0	40, 134		40, 134	1
69. 00	06900 ELECTROCARDI OLOGY	460, 264		460, 264		460, 264	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	623, 830		623, 830		623, 830	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	468, 762	l .	468, 762		468, 762	
	07300 DRUGS CHARGED TO PATIENTS	2, 100, 015		2, 100, 015		2, 100, 015	
70.00	OUTPATIENT SERVICE COST CENTERS	2, 100, 010		2, 100, 010	<u> </u>	2, 100, 010	70.00
88. 00	08800 RURAL HEALTH CLINIC	4, 739, 840		4, 739, 840	0	4, 739, 840	88. 00
	08801 RURAL HEALTH CLINIC II	1, 497, 936	l .	1, 497, 936		1, 497, 936	
	08802 RURAL HEALTH CLINIC (RHC)	451, 840	l .	451, 840		451, 840	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.01,010	0	0.01,010	1
90.00	09000 CLI NI C	278, 381		278, 381	0	278, 381	
91. 00	09100 EMERGENCY	4, 310, 959		4, 310, 959		4, 310, 959	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	319, 061		319, 061		319, 061	1
72.00	OTHER REIMBURSABLE COST CENTERS	0177001		0177001		0.7700.	1 /2: 00
99. 10	09910 CORF	0		C		0	99. 10
,,,,,	SPECIAL PURPOSE COST CENTERS						1 //
109 00	10900 PANCREAS ACQUISITION	0		С		0	109. 00
	11000 INTESTINAL ACQUISITION	0		i o			110.00
	11100 SLET ACQUISITION	0		Ö			111. 00
	11300 I NTEREST EXPENSE						113. 00
200.00		28, 999, 827	0	28, 999, 827	0	28, 999, 827	
201.00	,	319, 061		319, 061		319, 061	
202. 00		28, 680, 766	0				
202.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20,000,700	1	20,000,700	١	20,000,700	1-32.00

CARLE EUREKA HOSPITAL	In Lie	u of Form CMS-2552-10
Provi der CCN: 14-1309	Peri od:	Worksheet C
	Provider CCN: 14-1309	

					rom 01/01/2023 o 12/31/2023	Part Date/Time Pre 5/29/2024 8:5	
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
	LABORT BUT DOUTLAND OFFICE OF COURT OFFICE OF	6. 00	7. 00	8. 00	9. 00	10. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 005 000		1 005 000			20.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 925, 833		1, 925, 833			30.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0					33.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0					41.00
42.00	ANCI LLARY SERVI CE COST CENTERS	Ч					42. 00
50. 00	05000 OPERATING ROOM	12, 265	1, 100, 788	1, 113, 053	2. 145352	0. 000000	50.00
53. 00	05300 ANESTHESI OLOGY	19, 594	618, 372	637, 966	l .	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	997, 137	11, 306, 229			0. 000000	
57. 00	05700 CT SCAN	0	11, 000, 227	12, 000, 000	0. 000000	0. 000000	
58. 00	05800 MRI	0	0	ĺ		0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	ď	0. 000000	0. 000000	
60.00	06000 LABORATORY	828, 265	7, 351, 544	8, 179, 809		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0	C C	0. 000000	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	d	0. 000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	2, 034	754, 377	756, 411	0. 303984	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	304, 923	1, 032, 104	1, 337, 027	0. 758436	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	52, 561	288, 109	340, 670	1. 004171	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	4, 110	628	4, 738	8. 470663	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	69, 718	1, 115, 985	1, 185, 703	0. 388178	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	42, 543	359, 719	402, 262	1. 550805	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	136, 157	388, 122	524, 279		0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 522, 368	2, 759, 099	4, 281, 467	0. 490490	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	6, 187, 188			0. 000000	
88. 01	08801 RURAL HEALTH CLINIC II	0	1, 619, 391	1, 619, 391	0. 925000	0. 000000	
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	239, 986			0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.000000	0. 000000	
90.00	09000 CLI NI C	1, 151	340, 373			0.000000	
91.00	09100 EMERGENCY	368, 010	6, 368, 706	6, 736, 716	l	0.000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	266, 992	243, 168	510, 160	0. 625414	0. 000000	92.00
00 10	OTHER REIMBURSABLE COST CENTERS						00 10
99. 10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	C			99. 10
100.00	10900 PANCREAS ACQUISITION	0	0	C	0. 000000	0. 000000	100.00
	11000 INTESTINAL ACQUISITION		0			0.000000	
	11100 I SLET ACQUI SI TI ON		0			0. 000000	
	11300 INTEREST EXPENSE	١	0		0.000000	0. 000000	113. 00
200.00	1	6, 553, 661	42, 073, 888	48, 627, 549			200. 00
201.00		0, 333, 001	72, 073, 000	70,027,347			201. 00
202.00	1 1	6, 553, 661	42, 073, 888	48, 627, 549			202. 00
50	, , , , , , , , , , , , , , , , , , , ,	2,000,001	, 0, 0, 000		1		,

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1309	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

			To 12/31/2023	Date/Time Prepared: 5/29/2024 8:55 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
33.00 03300 BURN INTENSIVE CARE UNIT				33. 00
41. 00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42. 00
ANCILLARY SERVICE COST CENTERS	0.000000			50.00
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
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	0. 000000			
	1			88. 01
	0. 000000 0. 000000			88. 02 89. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0. 000000			90.00
91. 00 09100 EMERGENCY	1			90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS	0. 000000			92.00
99. 10 09910 CORF				99. 10
SPECIAL PURPOSE COST CENTERS				99. 10
109. 00 10900 PANCREAS ACQUISITION	0. 000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0. 000000			110. 00
111. 00 11100 SLET ACQUISITION	0. 000000			111. 00
113. 00 11300 NTEREST EXPENSE	0.000000			113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1			1

Health Financial Systems	CARLE EUREKA H	IOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLA	RY SERVICE CAPITAL COSTS	Provider CCN: 14-1309	Peri od:	Worksheet D

Health Financial Systems	CARLE EUREK	A HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre	pared:
					5/29/2024 8: 5	5 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1	1			
50. 00 05000 OPERATING ROOM	100, 809					
53. 00 05300 ANESTHESI OLOGY	4, 611	637, 966	1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	128, 560	12, 303, 366				
57. 00 05700 CT SCAN	0	0	0.00000		0	
58. 00 05800 MRI	0	0	0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	10.000	0 470 000	0.00000		0	59.00
60. 00 06000 LABORATORY	10, 966	8, 179, 809			463	1
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	1 (10	757 411	0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 610					65.00
66. 00 06600 PHYSI CAL THERAPY	11, 781	1, 337, 027				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	8, 050					67. 00
68. 00 06800 SPEECH PATHOLOGY	5, 949	· ·	1			1
69. 00 06900 ELECTROCARDI OLOGY	3, 019					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	3, 435					71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 311 5, 794	524, 279			607	
OUTPATIENT SERVICE COST CENTERS	5, 794	4, 281, 467	0.00135	13 448, 903	607	73.00
88. 00 08800 RURAL HEALTH CLINIC	257, 616	6, 187, 188	0. 04163	37 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC I	40, 443				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC (RHC)	1, 209				0	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	1, 209		1		0	89. 00
90. 00 09000 CLINI C	1, 286	1	1		0	90.00
91. 00 09100 EMERGENCY	31, 020		1		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 830				·	
200.00 Total (lines 50 through 199)	627, 299		1	1, 550, 229		1
200.00 10tal (111103 00 till bugil 177)	021,277	1 40,701,710	Т	1, 550, 227	12, 344	1200.00

Health Financial Systems	CARLE EUREKA H	OSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1309		Worksheet D
			From 01/01/2022	Dorst IV

THROUGH COSTS From 01/01/2023 To 12/31/2023 Part IV Date/Time Prepared: 5/29/2024 8:55 pm Title XVIII Hospi tal Cost Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Program Anestheti st Program Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 1.00 ЗА 3.00 2A 2.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 57.00 05700 CT SCAN 0 0 57.00 0 0 05800 MRI 0 58.00 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 0 0 60.00 06000 LABORATORY 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 01 06400 I NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 64.00 0 0 64.00 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 0 0 0 0 0 0 0 0 0 08801 RURAL HEALTH CLINIC II 0 0 88. 01 88. 01 08802 RURAL HEALTH CLINIC (RHC) 88.02 0 0 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 0 0 0 0 0 90.00 09000 CLI NI C 0 90.00 91. 00 09100 EMERGENCY 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 Total (lines 50 through 199) 0 200. 00 200.00

Heal th Financial	Systems		CARLE EUREKA	HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY S	ERVICE OTHER PASS	Provider C		Peri od: From 01/01/2023	Worksheet D Part IV	
THROUGH COSTS							Date/Time Pre 5/29/2024 8:5	
				Ti tl e	XVIII	Hospi tal	Cost	
Cost	Center Description		All Other	Total Cost	Total	Total Charges	Ratio of Cost	
			Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
				4)	col s. 2, 3,	8)	7)	
					and 4)		(see	
							instructions)	

				AVIII	nospi tai	L	
	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	
	NCILLARY SERVICE COST CENTERS	1			1		
	05000 OPERATING ROOM	0	0	0	1, 113, 053		
	05300 ANESTHESI OLOGY	0	0	0	637, 966	l	1
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	12, 303, 366	l	1
	05700 CT SCAN	0	0	0	0	0.000000	1
	05800 MRI	0	0	0	0	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0.000000	59. 00
	06000 LABORATORY	0	0	0	8, 179, 809	0.000000	60.00
	06001 BLOOD LABORATORY	0	0	0	0	0.000000	60. 01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	0	756, 411	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	1, 337, 027	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	340, 670	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	4, 738	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	1, 185, 703	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	402, 262	0.000000	71. 00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	524, 279	0.000000	72. 00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	0	0	0	4, 281, 467	0.000000	73. 00
0	OUTPATIENT SERVICE COST CENTERS						1
88.00 0	08800 RURAL HEALTH CLINIC	0	0	0	6, 187, 188	0.000000	88. 00
88. 01 0	08801 RURAL HEALTH CLINIC II	0	0	0	1, 619, 391	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	0	0	239, 986	0.000000	88. 02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	0	341, 524	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	6, 736, 716	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	510, 160	0.000000	92. 00
200.00	Total (lines 50 through 199)	0	0	0	46, 701, 716		200. 00
	•	•	•	•	•	•	

Health Financial Systems	CARLE EUREKA	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER PASS	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/29/2024 8:5	
		Ti tl e	: XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	

From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/29/2024 8:55 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From 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 3.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2. 145352 262, 821 0 50.00 53.00 05300 ANESTHESI OLOGY 1.016623 123, 150 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 158222 2, 915, 137 54 00 0 54 00 0 05700 CT SCAN 57.00 0.000000 0 0 0 57.00 58. 00 | 05800 MRI 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 59.00 06000 LABORATORY 0. 291150 0 60.00 1, 990, 677 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0 0 64.00 06500 RESPIRATORY THERAPY 0.303984 261, 234 65 00 65 00 0 06600 PHYSI CAL THERAPY 66.00 0.758436 410, 541 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 1.004171 51, 591 0 67.00 68.00 06800 SPEECH PATHOLOGY 8. 470663 0 68.00 340 477, 548 69. 00 06900 ELECTROCARDI OLOGY 0. 388178 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1.550805 0 73, 301 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.894108 59, 234 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 490490 749, 640 0 73.00 OUTPATIENT SERVICE COST CENTERS

0.815114

0. 639920

0.625414

34, 452

85, 676

1, 360, 809

8, 856, 151

8, 856, 151

0

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89 00

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92.00

201.00

0 200. 00

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0 90.00

0

88.00

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88.02

89.00

90.00

91.00

92.00

200.00

201.00

202.00

08800 RURAL HEALTH CLINIC

Only Charges

09000 CLI NI C

09100 EMERGENCY

08801 RURAL HEALTH CLINIC II

08802 RURAL HEALTH CLINIC (RHC)

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Subtotal (see instructions)

Health Financial Systems		CARLE EUREKA H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provider CCN: 14-1309	Peri od: From 01/01/2023	Worksheet D Part V
					D-+- /T! D

				From 01/01/2023 To 12/31/2023	Part V Date/Time Pr 5/29/2024 8:	
			XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7.00				
50. 00 05000 OPERATING ROOM	563, 844	0				50.00
53. 00 05300 ANESTHESI OLOGY	125, 197	0				53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1					54.00
57. 00 05700 CT SCAN	461, 239	0				57.00
58. 00 05800 MRI		0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0				59.00
60. 00 06000 LABORATORY	E70 F04	0				60.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	579, 586	0				60.00
64. 00 06400 NTRAVENOUS THERAPY		0				64.00
65. 00 06500 RESPIRATORY THERAPY	70 411	0				65.00
66. 00 06600 PHYSI CAL THERAPY	79, 411 311, 369	0				66.00
67. 00 06700 OCCUPATIONAL THERAPY	51, 806	0				67.00
68. 00 06800 SPEECH PATHOLOGY	2, 880	0				68.00
69. 00 06900 SPEECH PATHOLOGY	185, 374					69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	113, 676					71. 00
72. 00 07100 Medical Supplies Charged to Patient 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	52, 962					71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	367, 691					73. 00
OUTPATIENT SERVICE COST CENTERS	307, 091					73.00
88. 00 08800 RURAL HEALTH CLINIC						88. 00
88. 01 08801 RURAL HEALTH CLINIC II						88. 01
88. 02 08802 RURAL HEALTH CLINIC (RHC)						88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLI NI C	28, 082					90.00
91. 00 09100 EMERGENCY	870, 809					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	53, 583					92.00
200.00 Subtotal (see instructions)	3, 847, 509	0				200. 00
201. 00 Less PBP Clinic Lab. Services-Program	3, 047, 309					201. 00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	3, 847, 509	0				202. 00
232. 33 ₁	3,317,307	1	1			1-02.00

Health Financial Systems	CARLE EUREKA	HOSPI TAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN	NCILLARY SERVICE OTHER PASS	Provider CO	CN: 14-1309	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023		
		Component (CCN: 14-Z309	To 12/31/2023		
					5/29/2024 8: 55	pm
		Title	XVIII	Swing Beds - SNF	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stendown		Adiustments		

					5/29/2024 8:5	5 pm
		Title	XVIII	Swing Beds - SNI	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1	0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0	0	54.00
57.00 05700 CT SCAN	0	0)	0 0	0	57. 00
58. 00 05800 MRI	0	0	1	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 0	0	59. 00
60. 00 06000 LABORATORY	0	0)	0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0)	0 0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0)	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0)	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	,	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
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 (RHC)	0	0)	0 0	0	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	,	0	Ō	89. 00
90. 00 09000 CLINIC	0	0	,	0	Ō	90.00
91, 00 09100 EMERGENCY		0	,	0	Ō	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ		o	0	92.00
200.00 Total (lines 50 through 199)		0	,	o c	n	200.00
	1	'	1	-1	1	

	Financial Systems	CARLE EUREK				eu of Form CMS-	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi der C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre	nared:
			Component	OON: 11 2007	12/01/2020	5/29/2024 8:5	5 pm
					Swing Beds - SNF		
	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)	
	ANOULLARY OFRICE COOT OFFITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS				0 4 440 050	0.000000	F0 00
50.00	05000 OPERATI NG ROOM	0	1	H	0 1, 113, 053		
53. 00	05300 ANESTHESI OLOGY	0	Ĭ	1	0 637, 966		
	05400 RADI OLOGY-DI AGNOSTI C	0	0	2	0 12, 303, 366		
	05700 CT SCAN	0		2	0	0.000000	
58. 00	05800 MRI	0	0)	0	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0.000000	
60.00	06000 LABORATORY	0	0)	0 8, 179, 809		
60. 01	06001 BL00D LABORATORY	0	0)	0	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0)	0	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0)	0 756, 411	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0)	0 1, 337, 027		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0)	0 340, 670		
68. 00	06800 SPEECH PATHOLOGY	0	0)	0 4, 738		
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0 1, 185, 703		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 402, 262		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	1	0 524, 279		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 281, 467	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS	T					
88. 00	08800 RURAL HEALTH CLINIC	0	0)	0 6, 187, 188		
88. 01	08801 RURAL HEALTH CLINIC II	0	0)	0 1, 619, 391	l .	
	08802 RURAL HEALTH CLINIC (RHC)	0	0)	0 239, 986		
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0	0. 000000	
	09000 CLI NI C	0	0)	0 341, 524	l .	
91.00	09100 FMERGENCY	1 0	l o	ol .	0 6, 736, 716	0.000000	91.00

341, 524 6, 736, 716 510, 160 46, 701, 716

91.00

92.00 200. 00

0.000000

0.000000

91. 00 09100 EMERGENCY

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Health Financial Systems	CARLE EUREKA	HOSDI TAI		In Lie	eu of Form CMS-	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		Provi der CO	CN: 14-1309 CCN: 14-Z309	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre	pared:
		Title	XVIII	Swing Beds - SNF	5/29/2024 8:5 Cost	5 pm
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
·	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.	ŭ	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						
50. 00 05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	66, 976		0	0	54.00
57. 00 05700 CT SCAN	0. 000000	0		0	0	57.00
58. 00 05800 MRI	0. 000000	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	109, 422		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	155, 943		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	27, 704		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	1, 227		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	4, 446		0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	277		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	312, 945		0	0	73.00
OUTPATIENT SERVICE COST CENTERS				<u>'</u>		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		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 (RHC)	0. 000000	0		0	0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	649		0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92.00
200.00 Total (lines 50 through 199)		679, 589		0 0	0	200. 00

Health Financial Systems	CARLE EUREKA HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1309	Peri od:	Worksheet D

	Trianciai Systems	CARLL LURER			III LI C	u or roriii cws-	2332-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider CO	F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet D Part V Date/Time Pre 5/29/2024 8:5	
			Ti tl	e XIX	Hospi tal	Cost	· ·
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	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	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_			_		
	05000 OPERATING ROOM	2. 145352	l .	(0	0	00.00
	05300 ANESTHESI OLOGY	1. 016623	l .	(0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 158222	l .	(0	0	54.00
	05700 CT SCAN	0. 000000	l .	(0	0	57. 00
58.00	05800 MRI	0. 000000	0	(0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	(0	0	59. 00
60.00	06000 LABORATORY	0. 291150	0	(0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	(0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	(0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 303984	0	(0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 758436	0	(0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1. 004171	0	(0	0	67.00
68.00	06800 SPEECH PATHOLOGY	8. 470663	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 388178	0	(0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 550805	0	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 894108	0	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 490490	0	(0	0	73.00
	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 (RHC)						88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLI NI C	0. 815114	0	(0	0	90.00
	09100 EMERGENCY	0. 639920		(0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 625414	0) (0	0	92.00
200.00	Subtotal (see instructions)		0	(0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	(0	0	202. 00

Health Financial Systems	CARLE EUREKA HOSPITAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 14-1309	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prep 5/29/2024 8:55	
		Ti tl	e XIX	Hospi tal	Cost	
	Co	osts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				

			11 (1	e ALA	nospi tai	COST	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00				
	NCILLARY SERVICE COST CENTERS	_	1	1			
	5000 OPERATI NG ROOM	0	0				50. 00
	5300 ANESTHESI OLOGY	0	0	1			53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
	5700 CT SCAN	0	0	1			57. 00
	5800 MRI	0	0	1			58. 00
	5900 CARDI AC CATHETERI ZATI ON	0	0	1			59. 00
	6000 LABORATORY	0	0	1			60.00
	6001 BLOOD LABORATORY	0	0	1			60. 01
	6400 I NTRAVENOUS THERAPY	0	0	1			64. 00
	6500 RESPI RATORY THERAPY	0	0	1			65. 00
	6600 PHYSI CAL THERAPY	0	0	1			66. 00
	6700 OCCUPATIONAL THERAPY	0	0	1			67. 00
	6800 SPEECH PATHOLOGY	0	0	1			68. 00
	6900 ELECTROCARDI OLOGY	0	0	1			69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1			72. 00
_	7300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
	UTPATIENT SERVICE COST CENTERS	T	T	T			
	8800 RURAL HEALTH CLINIC						88. 00
	8801 RURAL HEALTH CLINIC II						88. 01
	8802 RURAL HEALTH CLINIC (RHC)						88. 02
	8900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
	9000 CLI NI C	0	0				90. 00
	9100 EMERGENCY	0	0	1			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
200.00	Subtotal (see instructions)	0	0	1			200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	0	0	1			202. 00

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1309	Peri od: From 01/01/2023		
		To 12/31/2023	Date/Time Prep 5/29/2024 8:5	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

		Title XVIII	Hospi tal	Cost	o piii
	Cost Center Description	<u> </u>			
	DART I ALL PROVIDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s. excludina newborn)		1, 726	1. 00
2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		851	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4 00	do not complete this line.			740	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		31 of the cost	743 753	4. 00 5. 00
0.00	reporting period	om days) till dagn becomber	or or the cost	, 00	0.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line)		04 6 11	400	7.00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 OF the COST	122	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n davs) after December 31	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	, .,			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	337	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private re	om dave)	E40	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Ulli days)	500	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, er			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including private	room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conly (including private	room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed d	ays)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost		17. 00
	reporting period	Ü			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	159. 00	10 00
19.00	reporting period	s thi dagir becember 31 or	the cost	137.00	17.00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	159. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		4, 758, 051	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	4, 738, 031	
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost reportin	a neriod (line	19, 398	24 00
21.00	7 x line 19)	or or the dest reporting	g perrou (rriic	17, 070	21.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			2, 243, 963	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		2, 514, 088	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			,	
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	rges)		28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	Line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		i ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost dif	forential (line	0 2, 514, 088	36. 00 37. 00
37.00	27 minus line 36)	and private room cost urr	. c. c.i.c. (Title	2, 314, 000	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			0.051.==	00.00
38.00	Adjusted general inpatient routine service cost per diem (see	•		2, 954. 27 995, 589	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		995, 589	
	Total Program general inpatient routine service cost (line 39	,		995, 589	

	Financial Systems	CARLE EUREK	A HOSPITAL			eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 14-1309	Peri od: From 01/01/2023	Worksheet D-1	
					To 12/31/2023		
			Ti +I	le XVIII	Hospi tal	5/29/2024 8:5 Cost	5 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Day	/sDiem (col. 1	÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	11.00	2100	0.00	11 00	0.00	42. 00
	Intensive Care Type Inpatient Hospital Units		1	_			
43.00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
	BURN INTENSIVE CARE UNIT	0		0 0.0	00	0	1
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			704, 981	48. 00
	Program inpatient cellular therapy acquisiti				column 1)	0	
49. 00	Total Program inpatient costs (sum of lines	41 through 48.(01)(see instru	uctions)		1, 700, 570	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst D sun	of Parts L and	0	50.00
00.00	III)	atront routine	301 11 003 (110	om with by our	or raits r and		00.00
51.00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	from Wkst. D, s	sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
	Total Program inpatient operating cost exclu	,	elated, non-ph	nysician anesth	netist, and	Ö	
	medical education costs (line 49 minus line	52)	<u> </u>				
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					I 0	54.00
	Target amount per discharge						55.00
55. 01	Permanent adjustment amount per discharge						55. 01
	Adjustment amount per discharge (contractor						55. 02
	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			(Lino 56 minus	Lino 52)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	arget amount ((TITIE 30 IIITIUS	111le 55)		
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	porting period	endi ng 1996,	0.00	59. 00
40.00	updated and compounded by the market basket)	or line EE fro	om prior voor	cost roport	indated by the	0.00	60.00
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or time 55 fro	on prior year	cost report, t	ipuated by the	0.00	60.00
61.00	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 enter zero. (see instructions)	60), Of 1 % Of	the target a	allount (Tine 50	o), otherwise		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost reporti	ng period (See	1, 654, 391	64. 00
0 11 00	instructions)(title XVIII only)	to till odgi. Door	5 . 201	. о осот торот т	g po ou (000	1,001,071	000
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	Lonly) for	1, 654, 391	66. 00
	CAH, see instructions				•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	f the cost repo	orting period	0	68. 00
00.00	(line 13 x line 20)				n tring portou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil					I	70.00
	Adjusted general inpatient routine service c	-					71.00
	Program routine service cost (line 9 x line						72. 00
	Medically necessary private room cost applic						73. 00 74. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	,		•	Part II, column		75.00
	26, line 45)		, -	, ,			
	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00			orovi der recor	rds)			79.00
80.00	Total Program routine service costs for comp	arison to the o		*.	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		1)				81.00
82. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
83.00							

Health Financial Systems	CARLE EUREKA	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 8:55	
		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	146, 589	4, 758, 051	0. 03080	9 319, 061	9, 830	90.00
91.00 Nursing Program cost	0	4, 758, 051	0.00000	0 319, 061	0	91.00
92.00 Allied health cost	0	4, 758, 051	0.00000	0 319, 061	0	92.00
93.00 All other Medical Education	0	4, 758, 051	0.00000	0 319, 061	0	93.00

	Financial Systems	CARLE EUREKA HOSPITAL			u of Form CMS-	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1309	Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			707 400		
	03000 ADULTS & PEDIATRICS			727, 482		30.00
33. 00	03300 BURN INTENSIVE CARE UNIT			0		33. 00
41.00	04100 SUBPROVI DER - I RF			0		41.00
42. 00	04200 SUBPROVI DER			0		42.00
F0 00	ANCILLARY SERVICE COST CENTERS		0.4450	-0 0 47/	40.404	F0 00
			2. 1453!			
53.00	05300 ANESTHESI OLOGY		1. 01662		14, 848	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 15822		63, 384	
57. 00	05700 CT SCAN		0.00000		0	
58. 00	05800 MRI		0.00000		0	
59.00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60.00	06000 LABORATORY		0. 2911		100, 553	
60. 01	06001 BLOOD LABORATORY		0.00000		0	
64.00	06400 I NTRAVENOUS THERAPY		0.00000		0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 30398 0. 75843			
67.00	06700 OCCUPATI ONAL THERAPY		1. 0041		28, 546 3, 770	
68.00	06800 SPEECH PATHOLOGY		8. 4706		21, 981	
	06900 ELECTROCARDI OLOGY		0. 3881			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 55080			
71.00	107100 MEDICAL SUPPLIES CHARGED TO PATTENT		0. 89410			1
	07300 DRUGS CHARGED TO PATIENTS		0. 89410			1
73.00	OUTPATIENT SERVICE COST CENTERS		0.4904	90 448, 903	220, 212	73.00
00 00	08800 RURAL HEALTH CLINIC		0.0000	20	0	88. 00
88. 00	O8800 RURAL HEALTH CLINIC		0.00000		0	
88. 02	08801 RURAL HEALTH CLINIC II		0.00000		0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	1
	09000 CLINIC		0. 00000		0	
	09000 CLINIC		0.6131		0	

0.639920

0. 625414

95, 964 1, 550, 229

1, 550, 229

91.00

201. 00 202.00

60, 017 92. 00 704, 981 200. 00

91.00 09100 EMERGENCY

201.00

202.00

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

	Financial Systems	CARLE EUREKA HOSPITAL			eu of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od: From 01/01/2023	Worksheet D-3	
		Component	CCN: 14-Z309	To 12/31/2023	5/29/2024 8:5	
		Ti tl e		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x col .	
			1.00	2.00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS					30.00
33. 00	03300 BURN INTENSIVE CARE UNIT					33.00
41. 00	04100 SUBPROVI DER - I RF					41.00
42.00	04200 SUBPROVI DER					42.00
	ANCILLARY SERVICE COST CENTERS			•		1
50.00	05000 OPERATI NG ROOM		2. 14535	2 0	0	50. 00
53.00	05300 ANESTHESI OLOGY		1. 01662	3 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 15822		10, 597	54. 00
57.00	05700 CT SCAN		0. 00000		1	
58. 00	05800 MRI		0. 00000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60.00	06000 LABORATORY		0. 29115			1
60. 01	06001 BLOOD LABORATORY		0.00000		1	60. 01
	06400 I NTRAVENOUS THERAPY		0.00000		1	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 30398 0. 75843		110 272	65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY		1. 00417	· ·		
68. 00	06800 SPEECH PATHOLOGY		8. 47066	· ·	10, 394	1
	06900 ELECTROCARDI OLOGY		0. 38817			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 55080		430	1
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 89410			72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 49049		_	
	OUTPATIENT SERVICE COST CENTERS			5.27.13		1
88. 00	08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0. 00000	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)		0. 00000	0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
	09000 CLI NI C		0. 81511			1
91 NA	00100 EMEDGENCY		0 63992	0	l 0	91 00

91. 00

92.00 0 355, 123 200. 00

201. 00 202. 00

0. 639920

0. 625414

91. 00 09100 EMERGENCY

201.00 202.00

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 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)

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1309	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared:

	Title Will Hereitel	5/29/2024 8: 5	5 pm
	Title XVIII Hospital	Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3, 847, 509	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3. 00 4. 00	OPPS or REH payments	0	
4. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	0	4.00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
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 direct graduate medical education costs from	0	9.00
10.00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions		10.00
10. 00 11. 00	Total cost (sum of lines 1 and 10) (see instructions)	0 3, 847, 509	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	3, 047, 307	11.00
	Reasonabl e charges		İ
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
45.00	Customary charges	1	
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
	Total customary charges (see instructions)	0	1
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19.00
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
21 00	instructions) Lesser of cost or charges (see instructions)	2 005 004	21 00
	Interns and residents (see instructions)	3, 885, 984 0	21. 00 22. 00
	Cost of physicians' services in a teaching hospital (see instructions)	Ö	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	Ö	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u>'</u>	ĺ
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	28, 862	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1, 405, 347	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	2, 451, 775	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
28. 50	REH facility payment amount (see instructions)	٥	28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27, 28, 28.50 and 29)	2, 451, 775	30.00
31.00	Primary payer payments	652	
32. 00	Subtotal (line 30 minus line 31)	2, 451, 123	32.00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		00.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)	0 61, 615	
35. 00	Adjusted reimbursable bad debts (see instructions)	40, 050	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	61, 615	
	Subtotal (see instructions)	2, 491, 173	
38. 00	MSP-LCC reconciliation amount from PS&R	0	38. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
	Pioneer ACO demonstration payment adjustment (see instructions)	_	39. 50
	N95 respirator payment adjustment amount (see instructions)	0	
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
39. 98 39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions)	2, 491, 173	
40. 01	Sequestration adjustment (see instructions)	49, 823	1
	Demonstration payment adjustment amount after sequestration	0	
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
	Interim payments	2, 750, 312	
	Interim payments-PARHM Tentetive settlement (for contractors use only)	_	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0	42. 00 42. 01
42.01	Balance due provider/program (see instructions)	-308, 962	
43. 00	Balance due provider/program-PARHM (see instructions)	-300, 702	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions)	0	
	Outlier reconciliation adjustment amount (see instructions)	0	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	92. 00 93. 00
7J. UU	Time value of money (see first detroits)	1 0	73.00

Health Financial Systems	CARLE EUREKA HO	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1309	Peri od: From 01/01/2023 To 12/31/2023		pared:
				5/29/2024 8:5	
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/29/2024 8:55 pm	Provider CCN: 14-1309

					5/29/2024 8: 55	5 pm
			XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 298, 744		2, 580, 085	1. 0
2. 00	Interim payments payable on individual bills, either		, , , , ,		0	2. 0
	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. 0
	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	09/05/2023	221, 109		134, 199	3. 0
3. 02		12/04/2023	54, 218		36, 028	3. 0
3. 03			(0	3. 0
3. 04			(0	3. 0
3. 05			()	0	3. 0
	Provi der to Program		_		_	
3. 50	ADJUSTMENTS TO PROGRAM		(0	3. 5
5. 51			(0	3. 5
5. 52			(0	3. 5
3. 53			(0	3. 5
3. 54			(0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		275, 327		170, 227	3. 9
4. 00	3.50-3.98)		1 574 071		2 750 212	4.0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 574, 071		2, 750, 312	4. 0
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1				
5. 00	List separately each tentative settlement payment after					5. 0
7. 00	desk review. Also show date of each payment. If none,					0.0
	write "NONE" or enter a zero. (1)					
	Program to Provider	'		1		
5. 01	TENTATI VE TO PROVI DER		()	0	5.0
5. 02					0	5. 0
5. 03			(0	5. 0
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 5
5. 51			(0	5. 5
5. 52			()	0	5. 5
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 9
	5. 50-5. 98)					
5. 00	Determined net settlement amount (balance due) based on					6. 0
	the cost report. (1)					
5. 01	SETTLEMENT TO PROVI DER		()	0	6. 0
5. 02	SETTLEMENT TO PROGRAM		22, 083		308, 962	6. 0
7. 00	Total Medicare program liability (see instructions)		1, 551, 988		2, 441, 350	7. 0
				Contractor	NPR Date	
			`	Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
3. 00	Name of Contractor	NATI ONAL GOVER			2.00	8. 0

Provider CCN: 14-1309 Component CCN: 14-Z309

					5/29/2024 8: 5	5 pm
				ving Beds - SNF		
		I npati en	nt Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		1, 964, 442		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	09/05/2023	204, 801		0	
3. 02		12/04/2023	13, 870		0	
3. 03			0		0	3. 03
3.04			0		0	3. 04
3. 05			0		0	3. 05
	Provi der to Program	1				
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	
3. 52			0		0	
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		218, 671		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		2 102 112		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 183, 113		0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		'	l	'	1
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program]
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					, .
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		203, 064		0	
7. 00	Total Medicare program liability (see instructions)		1, 980, 049		0	7. 00
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
9 00	Name of Contractor		O NMENT SERVICES	1.00	2. 00	0.00
8. 00	Name of Contractor	INC.	INIVICINI SERVICES	06101		8. 00
	I and the second	li 140.		ļ	I	I

Health Financial Systems CARLE EUREKA HOSPITAL In Lieu					2552-10
From 01/01/2023 To 12/31/2023 To 12/31/202 To 1					epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 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 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	31.00 Other Adjustment (specify)				
32. 00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32. 00

		Component CCN: 14-Z309	To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
		Title XVIII	Swing Beds - SNF		<u> </u>
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPDED CERTIFICATION		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		1 470 025	0	1.00
2. 00	Inpatient routine services - swing bed-SNF (see instructions)		1, 670, 935	U	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	358, 674	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin			· ·	0.00
	instructions)	3 [
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	etructions)	560	0	5. 00 6. 00
6. 00 7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional met	hod only	0	0	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	flod offi y	2, 029, 609	0	8.00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10. 00	Subtotal (line 8 minus line 9)		2, 029, 609	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
	professional services)	. 3			
12.00	Subtotal (line 10 minus line 11)		2, 029, 609	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	9, 151	0	13. 00
	for physician professional services)			_	
14.00	80% of Part B costs (line 12 x 80%)		2 020 450	0	14.00
15.00	Subtotal (see instructions)		2, 020, 458	0	15.00
16. 00 16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	1	0	U	16. 00 16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	,	0		16. 55
10. 55	adjustment (see instructions)	ati on) payment			10. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	18. 00
19. 00	Total (see instructions)		2, 020, 458	0	19. 00
19. 01	Sequestration adjustment (see instructions)		40, 409	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)		2 102 112	0	19. 25
20. 00 20. 01	Interim payments		2, 183, 113	0	20. 00 20. 01
21. 00	Interim payments-PARHM Tentative settlement (for contractor use only)		0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)			· ·	21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	. 19, 25, 20, and 21)	-203, 064	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from W	kst N_1 Pt II line			201. 00
201.00	66 (title XVIII hospital))	KSt. D I, It. II, IIIC			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lin	e		202. 00
	200 (title XVIII swing-bed SNF))				
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	ration	
205 00	period) Medicare swing-bed SNF target amount				205 00
	, , , , , , , , , , , , , , , , , , , ,	mas line 204)			205. 00 206. 00
200.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207 00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1		208.00
200.00	and 3)	, cor. I, sam of fines	•		200.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1309	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 8:55 pm

				5/29/2024 8:55	5 pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PA	RT A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 700, 570	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2. 00
3.00	Organ acquisition		0	3. 00	
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			1, 700, 570	4. 00
5. 00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 700, 570	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 700, 370	0.00
	Reasonable charges				
7. 00	Routi ne servi ce charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	10.00
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for pay	mont for convices on s	s charge basis	0	11. 00
				0	12.00
12. 00	Amounts that would have been realized from patients liable for p	ayment for services or	i a charge basis	U	12.00
12 00	had such payment been made in accordance with 42 CFR 413.13(e)			0. 000000	13. 00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)				
14.00	Total customary charges (see instructions)	: E : 14	() (0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only	IT TIME 14 exceeds IT	ie 6) (See	U	15. 00
1/ 00	instructions)	ifling (avacada lina	14) (000	0	1/ 00
16. 00	Excess of reasonable cost over customary charges (complete only	II Time 6 exceeds Time	e 14) (See	U	16. 00
17 00	instructions)	0	17 00		
17. 00	Cost of physicians' services in a teaching hospital (see instruc	ttions)		U	17. 00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1: 40)		0	10 00
18.00	Direct graduate medical education payments (from Worksheet E-4,	11 ne 49)		1 700 570	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 700, 570	
20.00	Deductibles (exclude professional component)			120, 000	20.00
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 580, 570	
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (line 22 minus line 23)			1, 580, 570	24. 00
25. 00	Allowable bad debts (exclude bad debts for professional services	(see instructions)		4, 756	25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)			3, 091	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		4, 756	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 583, 661	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 583, 661	30.00
30. 01	Sequestration adjustment (see instructions)			31, 673	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			1, 574, 071	31.00
31. 01	. 1.3				31. 01
32.00					
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02,	31, and 32)		-22, 083	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minu	s lines 30.03, 31.01,	and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accordance			0	34.00
	§115. 2		· · · · · · · · · · · · · · · · · · ·		
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Health Financial Systems CARLE EUREKA HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems

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

Provider CCN: 14-1309 Pe

OH y)					5/29/2024 8: 5	5 pm
		General Fund	Speci fi c	Endowment Fund	Pl ant Fund	
			Purpose Fund			
		1. 00	2.00	3. 00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	876, 968	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	8, 523, 538	0	0	0	4. 00
5.00	Other recei vable	64, 986	0	o	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-4, 825, 298	0	o	0	6. 00
7.00	Inventory	115, 302	0	o	0	7. 00
8.00	Prepai d expenses	63, 009	0	o	0	8. 00
9.00	Other current assets	0		o	0	9. 00
10.00	Due from other funds	0	0	o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	4, 818, 505	0	o	0	11. 00
	FIXED ASSETS					
12.00	Land	0	0	ol	0	12.00
13.00	Land improvements	0	0	ol	0	13.00
14.00	Accumul ated depreciation	0	0	o	0	14.00
15. 00	Bui I di ngs	0	0	o	0	15. 00
16. 00	Accumulated depreciation	0	0	ol	0	16. 00
17. 00	Leasehold improvements	0	o	ol	0	17. 00
18. 00	Accumulated depreciation	0	0	ol	0	18. 00
19. 00	Fi xed equipment	0	Ö	ol	0	19. 00
20. 00	Accumulated depreciation	0	Ö	ol	0	20. 00
21. 00	Automobiles and trucks	0	Ö	ol	0	21.00
22. 00	Accumulated depreciation	0	Ö	ő	0	22. 00
23. 00	Major movable equipment	3, 276, 114		0	o o	23. 00
24. 00	Accumulated depreciation	-1, 540, 605		0	o o	24. 00
25. 00	Mi nor equi pment depreci abl e	1, 340, 003	1	0	0	25. 00
26. 00	Accumulated depreciation		0	0	0	26. 00
27. 00	HIT designated Assets		0	0	0	27. 00
28. 00	Accumulated depreciation		0	o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e		0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	1, 735, 509		o	0	30.00
30.00	OTHER ASSETS	1, 730, 509	U	U	U	30.00
31. 00	Investments	0	0	0	0	31. 00
32. 00	Deposits on Leases	0	1	o	0	32.00
33. 00	Due from owners/officers		0	0	0	33. 00
34. 00	Other assets		0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)		0	0	0	35. 00
36. 00	1	6, 554, 014	0	0	0	36.00
30.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	0, 334, 014	l o	υ	U	30.00
37. 00	Accounts payable	49, 396	O	ol	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 401, 854		0	0	38.00
39. 00	Payroll taxes payable	1, 401, 654	1	0	0	39.00
40. 00	Notes and Loans payable (short term)		0	0	0	40.00
41. 00	Deferred income	107, 126	0	0	0	41.00
42. 00	Accel erated payments	107, 120		٩	١	42.00
43. 00	Due to other funds		0	0	0	43.00
44. 00	Other current liabilities	2, 348, 073		o	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	3, 906, 449		-		
45.00	LONG TERM LIABILITIES	3, 900, 449	0	0	0	45.00
46. 00	Mortgage payable	Ο	0	0	0	46. 00
47. 00	Notes payable			o	0	
48. 00	Unsecured Loans			0	0	
49. 00	Other long term liabilities			0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)			0	0	50.00
	,			0	0	51.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	3, 906, 449	l 0	U	U	31.00
52. 00	General fund balance	2, 647, 565				52. 00
53. 00	Specific purpose fund	2,047,303	0			53. 00
54. 00	Donor created - endowment fund balance - restricted		U	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	57.00
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)	2, 647, 565	0	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	6, 554, 014		0	0	
50.00	[59]	0, 334, 014		٩	ا	00.00
	1 * /	1	·	'	!	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES CARLE EUREKA HOSPITAL

In Lieu of Form CMS-2552-10

Period: Worksheet G-1
From 01/01/2023 Provider CCN: 14-1309

					Т		Date/Time Pre 5/29/2024 8:5	pared: 5 pm
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		874, 278			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		1, 773, 287 2, 647, 565			0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	o	2,047,303		0	O	0	4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00 9. 00		0			0		0	8. 00 9. 00
10. 00	Total additions (sum of line 4-9)		0		Ŭ	0	· -	10.00
11. 00	Subtotal (line 3 plus line 10)		2, 647, 565			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0		0	12. 00
13. 00 14. 00		0			0		0	13.00
15. 00		0			0		0	14. 00 15. 00
16. 00		0			0		Ö	16. 00
17. 00		0			0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		0			0	l .	18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2, 647, 565			0		19. 00
	paneet (Trie 11 minus Trie 10)	Endowment Fund	PI ant	Fund				
			7.00	2.00				
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0			1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)				Ŭ			2.00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5. 00 6. 00			0					5. 00 6. 00
7. 00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0			10. 00 11. 00
11. 00 12. 00	Deductions (debit adjustments) (specify)		0		U			12.00
13. 00	beautions (dear t aug us timents) (speeding)		0					13. 00
14. 00			0					14. 00
15. 00			0					15. 00
16. 00 17. 00			0					16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	0	O		0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	O			0			19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1309

			To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
	Cost Center Description	Inpatient	Outpati ent	Total	J PIII
	555 551161 55551 Pt 1511	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	1, 461, 36	5	1, 461, 365	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF		0	0	3. 00
4.00	SUBPROVI DER		0	0	4. 00
5.00	Swing bed - SNF	464, 46	8	464, 468	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	1, 925, 83	33	1, 925, 833	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT		0	0	13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 925, 83		1, 925, 833	17. 00
18. 00	Ancillary services	4, 607, 65			18. 00
19. 00	Outpati ent servi ces		0 0	0	19. 00
20. 00	RURAL HEALTH CLINIC		0 6, 187, 188	6, 187, 188	20. 00
20. 01	RURAL HEALTH CLINIC II		0 1, 619, 391	1, 619, 391	20. 01
20. 02	RURAL HEALTH CLINIC (RHC)		0 239, 986	239, 986	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
24. 10	CORF		0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	41 //	2 120 011	0 1/0 517	26. 00
27. 00	PROFESSIONAL FEES	41, 60		2, 162, 517	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	6, 575, 09	95 44, 214, 771	50, 789, 866	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		26, 729, 825		29. 00
30. 00	BAD DEBT	1, 340, 85			30. 00
31. 00	DAU DEUT	1, 540, 60	0		31. 00
32. 00			0		32. 00
33. 00			0		33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		1, 340, 855		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00	DEDUCT (SECULT)		0		38. 00
39. 00			ō		39. 00
40. 00			0		40. 00
41. 00			0		41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	28, 070, 680		43. 00
	to Wkst. G-3, line 4)		, 2.2, 300		
		•			

Heal th	Financial Systems	CARLE EUREKA HOSPITAL	In Lie	u of Form CMS-2	2552-10	
STATE	ENT OF REVENUES AND EXPENSES	Provi der CCN: 14-1309	Peri od:	Worksheet G-3		
	From 01/01/2023 To 12/31/2023					
4 00	T + 1	1 2 11 20)		1.00	4 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,			50, 789, 866		
2. 00 3. 00	Less contractual allowances and discounts on par Net patient revenues (line 1 minus line 2)	trents accounts		21, 334, 439 29, 455, 427	2. 00 3. 00	
4. 00	Less total operating expenses (from Wkst. G-2, I	Part II lina 42)		29, 455, 427		
5.00	Net income from service to patients (line 3 min			1, 384, 747		
5.00	OTHER INCOME	us iiile 4)		1, 304, 747	5.00	
6.00	Contributions, donations, bequests, etc			0	6. 00	
7. 00	Income from investments			0	7. 00	
8.00	Revenues from telephone and other miscellaneous	communication services		0		
9. 00	Revenue from television and radio service			0		
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11. 00	
12.00	Parking Lot receipts			0	12.00	
13.00	Revenue from Laundry and Linen service			0	13.00	
14.00	Revenue from meals sold to employees and guests			0	14.00	
15.00	Revenue from rental of living quarters			0	15.00	
16.00	Revenue from sale of medical and surgical suppli	es to other than patients		0	16.00	
17. 00	Revenue from sale of drugs to other than patien			0	17. 00	
18.00	Revenue from sale of medical records and abstraction				18.00	
	Tuition (fees, sale of textbooks, uniforms, etc.			0	19. 00	
20. 00	Revenue from gifts, flowers, coffee shops, and	canteen		0	20.00	
	Rental of vending machines			0		
22. 00	Rental of hospital space			0		
23. 00	Governmental appropriations			0	_0.00	
24. 00	OTHER			388, 540		
24. 50	COVI D-19 PHE Funding			0		
	Total other income (sum of lines 6-24)			388, 540		
	Total (line 5 plus line 25)			1, 773, 287		
27. 00	OTHER EXPENSES (SPECIFY)			0		
	Total other expenses (sum of line 27 and subscri			0	28. 00	
29.00	Net income (or loss) for the period (line 26 min	nus line 28)	l	1, 773, 287	29.00	

	n Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	CARLE EUREKA		ON 14 1200		u of Form CMS-1	
ANALYS	212 OF HOZSITAT-RAZED KHC\EGHC CO212		Provi der C	JN: 14-1309	Peri od: From 01/01/2023	Worksheet M-1	
			Component	CCN: 14-8581	To 12/31/2023	Date/Time Pre 5/29/2024 8:5	pared: 5 pm
					RHC I	Cost	
		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	1, 437, 081	283, 419			1, 720, 500	
2.00	Physician Assistant	78, 248				93, 680	
3.00	Nurse Practitioner	75, 169	1			89, 994	
4.00	Visiting Nurse	0	0		0 0	0	
5.00	Other Nurse	447, 374	88, 230	535, 60	04	535, 604	1
6. 00	Clinical Psychologist	0	0		0	0	
7.00	Clinical Social Worker	0	0		0	0	
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Technician	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	0 007 070	401 007	0 400 7	0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	2, 037, 872	401, 906	2, 439, 77		2, 439, 778	
11.00	Physician Services Under Agreement	0	0		0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
14.00	Medical Supplies	0	0 68, 431		-	-	
15. 00 16. 00	Transportation (Health Care Staff)	0	00, 431	68, 43	0	68, 431 0	1
17. 00	Depreciation-Medical Equipment	0	0		0	0	
18. 00	Professional Liability Insurance	0				0	
19. 00	Other Health Care Costs	0				0	1
20. 00	Allowable GME Costs	O	٥				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	68, 431	68, 43	81 0	68, 431	
22. 00	Total Cost of Health Care Services (sum of	2, 037, 872				2, 508, 209	
22.00	lines 10, 14, and 21)	2,007,072	170,007	2,000,20	,,	2,000,207	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		ļ.				
23. 00		0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	24. 00
25.00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 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	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29 00	Facility Costs	0	161. 698	161, 69	98 -149, 918	l 11. 780	29.00

610, 124

610, 124

2, 647, 996

161, 698 376, 520

538, 218

1, 008, 555

161, 698

986, 644

1, 148, 342

3, 656, 551

-149, 918

-149, 918

-149, 918

11, 780

986, 644

998, 424

3, 506, 633

29.00

30.00

31.00

32.00

29.00 Facility Costs

and 31)

30)

31.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	CARLE EUREKA 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: 14-8581	To 12/31/2023 Date/Time Prepared: 5/29/2024 8:55 pm			

Adjustments				Compone	11 001	N. 14-0501	10	12/31/2023	5/29/2024 8:	
For Al Tocation Cool								RHC I		
For Al Tocation Cool			Adjustments	Net Expens	es					
FACILITY HEALTH CARE STAFF COSTS										
FACILITY HEALTH CARE STAFF COSTS				(col. 5 + c	ol .					
FACILITY HEALTH CARE STAFF COSTS				6)						
1.00			6. 00							
1.00		FACILITY HEALTH CARE STAFF COSTS								
3.00	1.00	Physi ci an	0	1, 720,	500					1. 00
3.00	2.00	Physician Assistant	0	93,	680					2. 00
4.00	3.00		0	89.	994					3.00
5.00 Other Nurse 0 535,604 6.00	4.00	Visiting Nurse	0		ol					4.00
6.00 Clinical Psychologist 0 0 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.10 7.11 1.00 1.00 1.00 1.00 0 0 0 0 0 0 0 0 0		S .	0	535.	504					5.00
7.00 7.00 Narriage and Family Therapist 7.11 Mental Health Counsel or 7.11 Non 1.00 Narriage and Family Therapist 7.11 Non 1.00 N			0	,	1					
7.10		3 0	0		ol					•
7.11			, and the second		٦					
8.00 Company					1					•
9.00 Other Facility Heal th Care Staff Costs 0 0 0 0 Subtotal (sum of lines 1 through 9) 0 2,439,778 10.00 11.00			0							
10. 00 Subtotal (sum of lines 1 through 9) 0 2,439,778 10. 00			0		0					
11.00		,	0	2 430	778					
12.00		` ,	0	2, 437,	, , 0					
13. 00 Other Costs Under Agreement 0 0 0 0 14. 00 14. 00 14. 00 15. 00 0 0 0 0 0 0 0 0 0		J J	0							•
14. 00 Subtotal (sum of lines 11 through 13) 0 0 15. 00 Medical Supplies 0 68, 431 15. 00 17. 00 Depreciation-Medical Equipment 0 0 17. 00 18. 00 Professional Liability Insurance 0 0 17. 00 19. 00 Other Heal th Care Costs 0 0 19. 00 20. 00 Al lowable GME Costs 20. 00 21. 00 Subtotal (sum of lines 15 through 20) 0 68, 431 21. 00 22. 00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 0 2, 508, 209 23. 00 Pharmacy 0 0 23. 00 24. 00 Dental 0 0 24. 00 25. 01 Tel eheal th 0 0 25. 01 25. 02 Optometry 0 0 0 25. 01 Tel eheal th 0 0 0 25. 02 On In other nonreimbursable costs 0 0 0 27. 00 Total Nonreimbursable costs (sum of lines 23 0 0 0 28. 00 Total Nonreimbursable costs 0 0 0 30. 00 Administrative Costs 0 986, 644 30. 00 <			0							
15. 00 Medical Supplies		9	0							
16. 00		,	0	40	-1					1
17. 00 Depreciation-Medical Equipment 0 0 0 0 18. 00 Professional Liability Insurance 0 0 0 0 18. 00 19. 00 0 0 0 0 0 0 0 0 0		• • • • • • • • • • • • • • • • • • • •	0	00,						
18. 00 Professional Liability Insurance 0 0 19. 00 Other Health Care Costs 0 0 20. 00 Allowable GME Costs 20. 00 21. 00 Subtotal (sum of lines 15 through 20) 0 68, 431 22. 00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 21. 00 23. 00 Pharmacy 0 0 24. 00 Dental 0 0 25. 00 Optometry 0 0 25. 01 Tel eheal th 0 0 25. 02 Chronic Care Management 0 0 25. 02 All other nonrelimbursable costs 0 0 26. 00 All other nonrelimbursable costs 0 0 28. 00 Total Nonrelimbursable Costs (sum of lines 23) 0 0 29. 00 Facility Overhead 0 986, 644 31. 00 30 30 32. 00 Total facility costs (sum of lines 29 and 30) 0 3, 506, 633			0							
19.00 Other Health Care Costs 0 0 0 0 0 0 0 0 0		·	0							1
20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 68, 431 21.00 22.00 1 1 1 1 1 1 1 1 1		,	0							
21.00 Subtotal (sum of lines 15 through 20) 0 68, 431 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00 Costs Of Health Care Services (sum of lines 10, 14, and 21) 22.00 Costs Of Health Care Services (sum of lines 20, 14, and 21) 22.00 Costs Of Health Care Services (sum of lines 23, 200 23.00 24.00 24.00 24.00 24.00 25.00 26.00 26.00 26.00 27.00 26.00 27.00 28.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 2			U		U					•
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00		1	0		424					
Iines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES			0							
COSTS OTHER THAN RHC/FOHC SERVICES 23.00	22.00		0	2, 508,	209					22.00
23. 00 Pharmacy										
24.00 Dental 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 0 25.01 25.02 Chronic Care Management 0 0 0 0 25.02 26.00 All other nonreimbursable costs 0 0 0 26.00 27.00 Nonal lowable GME costs 0 0 0 28.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28.00 29.00 Facility Costs 0 986,644 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 3,506,633 32.00	22.00		0							1 22 00
25. 00			0		- 1					
25. 01 Tel eheal th			0		0					
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 29. 00 Facility Costs 0 11,780 30. 00 Administrative Costs 0 986,644 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 0 3,506,633 32. 00 32. 00 Total facility costs (sum of lines 22, 28 0 3,506,633 32. 00			0		0					
26.00 All other nonreimbursable costs 0 0 0 27.00 Nonallowable GME costs 27.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		0					
27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 through 27) 0 FACILITY OVERHEAD 0 11, 780 29. 00 Administrative Costs 0 986, 644 31. 00 Total Facility Overhead (sum of lines 29 and 30) 0 998, 424 32. 00 Total facility costs (sum of lines 22, 28 0 3, 506, 633 32. 00		<u> </u>	0		O					1
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 1 1,780 29.00 Facility Costs 0 986,644 30.00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 0 3,506,633 28.00 32.00			0		O					
through 27) FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 3, 506, 633 32.00										1
FACILITY OVERHEAD 29.00 Facility Costs 0 11,780 29.00 30.00 Administrative Costs 0 986,644 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 3,506,633 32.00	28. 00		0		O					28. 00
29.00 Facility Costs 0 11,780 29.00 30.00 Administrative Costs 0 986,644 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 998,424 31.00 32.00 Total facility costs (sum of lines 22, 28 0 3,506,633 32.00										
30.00 Administrative Costs 0 986,644 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 0 3,506,633 32.00	00.00		=1		700					00.05
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 3,506,633 32.00		,	0							
30) 32.00 Total facility costs (sum of lines 22, 28 0 3,506,633 32.00			0							
32.00 Total facility costs (sum of lines 22, 28 0 3,506,633 32.00	31. 00	,	0	998,	424					31.00
		,	_	0.5						
land 31)	32. 00	,	0	3, 506,	533					32.00
		lanu 31)			- 1					1

Heal th	Financial Systems	CARLE EUREKA	A HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO		Peri od:	Worksheet M-1	
					From 01/01/2023		
			Component	CCN: 14-8582	To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
					RHC II	Cost	о ріп
		Compensation	Other Costs	Total (col. 1	Recl assi 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	
4 00	FACILITY HEALTH CARE STAFF COSTS	20/ 407	00.005	405.00		405.000	4 00
1.00	Physi ci an	396, 197	89, 005	· ·		485, 202	1.00
2.00	Physician Assistant	150, 506	33, 811	184, 31	7	184, 317	2.00
3. 00 4. 00	Nurse Practitioner	0	0		0	0	3. 00 4. 00
4. 00 5. 00	Visiting Nurse Other Nurse	83, 751	18, 814	100 54	0	102, 565	5.00
6. 00	Clinical Psychologist	83, /51	18, 814	102, 56	0	102, 565	6.00
7. 00	Clinical Social Worker	0	0		0	0	7. 00
7. 10	Marriage and Family Therapist		0	'	0	0	7. 10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	n			0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	0	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	630, 454	141, 630	772, 08	4 0	772, 084	10.00
11. 00	Physician Services Under Agreement	0	0	,	o o	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14. 00
15.00	Medical Supplies	0	22, 769	22, 76	9 0	22, 769	15. 00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0		0	0	17. 00
	Professional Liability Insurance	0	0		0	0	18. 00
	Other Health Care Costs	0	0		0	0	19. 00
00 00	ALL II ONE O I	i i		1	1	1	1 00 00

0

630, 454

142, 533

142, 533

772, 987

0 0 0

0

0

0

139, 903

221, 084

360, 987

1, 155, 840

22, 769

794, 853

0

0

0 25.02

0

75, 510

221, 084

296, 594

1, 091, 447

22, 769

794, 853

-64, 393

-64, 393

-64, 393

20.00

21.00

22.00

23. 00

24.00

25.00

25.01

26.00

27.00

28. 00

29.00

30.00

31.00

32.00

0

0

139, 903

78, 551

218, 454

382, 853

22, 769

164, 399

20.00

21. 00

22.00

23. 00

24.00

25.00

25. 01

25.02

26.00

27.00

28. 00

31.00

32.00

Subtotal (sum of lines 15 through 20)

COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Allowable GME Costs

lines 10, 14, and 21)

Chronic Care Management

Nonallowable GME costs

Pharmacy

Optometry

Tel eheal th

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Dental

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1309	Period: Worksheet M-1 From 01/01/2023
	Component CCN: 14-8582	To 12/31/2023 Date/Time Prepared: 5/29/2024 8:55 pm

			·		5/29/2024 8:5	55 pm
				RHC II	Cost	
		Adjustments	Net Expenses			
		-	for Allocation			
			(col. 5 + col.			
			6)			
		6. 00	7. 00			
	FACILITY HEALTH CARE STAFF COSTS					
1.00	Physi ci an	0	485, 202			1.00
2.00	Physi ci an Assi stant	o	184, 317			2. 00
3.00	Nurse Practitioner	o	ol			3.00
4.00	Visiting Nurse	o	ol			4.00
5.00	Other Nurse	o	102, 565			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]	آ			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	o o	0			9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	772, 084			10.00
11. 00	Physician Services Under Agreement	o o	7,72,001			11. 00
12. 00	Physician Supervision Under Agreement	o o	0			12.00
13. 00	Other Costs Under Agreement	0	0			13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0			14. 00
15. 00	Medical Supplies	0	22, 769			15. 00
16. 00	Transportation (Health Care Staff)	0	22, 709			16.00
17. 00	Depreciation-Medical Equipment	0	0			17. 00
18. 00	Professional Liability Insurance	0	0			18. 00
19. 00	Other Health Care Costs	0	0			19. 00
20. 00	Allowable GME Costs	U	o _l			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	22, 769			21. 00
22. 00	Total Cost of Health Care Services (sum of	0	794, 853			22. 00
22.00	lines 10, 14, and 21)	٩	794,000			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES					
23. 00	Pharmacy	O	0			23. 00
24. 00	Dental	0	0			24. 00
25. 00	Optometry	0	0			25. 00
25. 00	Tel eheal th	0	0			25. 00
25. 01	Chronic Care Management	0	0			25. 02
26. 00	All other nonreimbursable costs	0	0			26. 00
27. 00	Nonal Lowable GME costs	o o	ď			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	o			28. 00
26.00	through 27)	٩	۷			20.00
	FACILITY OVERHEAD			 		+
29. 00	Facility Costs	ol	75, 510			29. 00
30.00	Administrative Costs	-12	221, 072			30.00
31.00	Total Facility Overhead (sum of lines 29 and	-12 -12	296, 582			31.00
31.00	30)	-12	270, 302			31.00
32. 00	Total facility costs (sum of lines 22, 28	-12	1, 091, 435			32. 00
32.00	and 31)	-12	1, 071, 433			32.00
	and or,	ļ	ı			1

Heal th	Financial Systems	CARLE EUREKA	HOSPI TAL		In Li€	eu of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1309	Peri od:	Worksheet M-1	
			Component	CCN: 14-8620	From 01/01/2023 To 12/31/2023		pared:
					RHC III	Cost	<u>o 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	0	
2.00	Physician Assistant	0	0	1	0	0	2. 00
3.00	Nurse Practitioner	126, 669	22, 387	149, 05	56 0	149, 056	
4.00	Visiting Nurse	0	0		0 0	0	4. 00
5.00	Other Nurse	38, 162	6, 745	44, 90	0	44, 907	5.00
6.00	Clinical Psychologist	0	Ü		0	0	1 0.00
7.00	Clinical Social Worker	0	Ü	1	0	0	,
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8. 00 9. 00	Laboratory Technician	0	0		0	0	
10.00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	164, 831	29, 132	193, 90	0	193, 963	
11. 00	, ,	104, 831	29, 132	193, 90	0	193, 963	1
12. 00	, ,	0	0		0	0	
13. 00	,	0	0			0	1
14. 00			0			0	
15. 00	Medical Supplies		6, 022	6, 02	22 0	6, 022	
16. 00			0, 022]	0 0	0, 022	1
	Depreciation-Medical Equipment	o	0		0 0	0	
18. 00	1 '	ol	0	,	0 0	l o	1
19. 00	1	o	0	,	0 0	0	1
20. 00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	o	6, 022	6, 02	22 0	6, 022	21.00
22.00		164, 831	35, 154	199, 98	35 0	199, 985	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		0	O		0 0	0	23. 00
24.00	Dental	0	0	1	0	0	
25. 00	Optometry	0	0	1	0 0	0	
25. 01	Tel eheal th	0	0	1	0	0	
25. 02	1 3 1 3 1 3	0	0	1	0 0	0	
26. 00	All other nonreimbursable costs	0	O	1	0	0	26. 00
27. 00	Nonallowable GME costs			1			27. 00

70, 326

70, 326

235, 157

28. 00

29.00

30.00

31.00

32.00

29, 776 98, 202

127, 978

327, 963

0

6, 192

6, 192

6, 192

23, 584

98, 202

121, 786

321, 771

23, 584 27, 876

51, 460

86, 614

28.00

31.00

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

Health Financial Systems	CARLE EUREKA HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1309	Period: Worksheet M-1 From 01/01/2023
	Component CCN: 14-8620	To 12/31/2023 Date/Time Prepared: 5/29/2024 8:55 pm

			Comporte	111 CCN. 14-0020	10 12/31/2023	5/29/2024 8:	
					RHC III	Cost	
		Adjustments	Net Expens	ses	'		
			for Allocat				
			(col. 5 + c	col.			
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS		•	<u> </u>			
1.00	Physi ci an	0)	0			1.00
2.00	Physi ci an Assi stant	0	j	ol			2.00
3.00	Nurse Practitioner	0	149.	056			3. 00
4.00	Visiting Nurse	0	1	0			4. 00
5. 00	Other Nurse	0	44	907			5. 00
6. 00	Clinical Psychologist		1 ' '	0			6. 00
7. 00	Clinical Social Worker			0			7. 00
7. 10	Marriage and Family Therapist			٩			7. 10
7. 10	Mental Health Counselor		•				7. 11
8. 00	Laboratory Techni ci an	0		0			8. 00
9. 00	Other Facility Health Care Staff Costs			0			9. 00
10. 00	Subtotal (sum of lines 1 through 9)		102	963			10.00
	, , , , , , , , , , , , , , , , , , , ,		193,	903			11.00
11. 00	Physician Services Under Agreement			0			
	Physician Supervision Under Agreement	0	<u>'</u>	0			12.00
	Other Costs Under Agreement	0	<u>'</u>	0			13.00
	Subtotal (sum of lines 11 through 13)	0	1	0			14. 00
15. 00	Medical Supplies	0	6,	022			15. 00
	Transportation (Health Care Staff)	0)	0			16. 00
	Depreciation-Medical Equipment	0)	0			17. 00
	Professional Liability Insurance	0)	0			18. 00
	Other Health Care Costs	0)	0			19. 00
	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0		022			21. 00
22. 00	Total Cost of Health Care Services (sum of	0	199,	985			22. 00
	lines 10, 14, and 21)						_
	COSTS OTHER THAN RHC/FQHC SERVICES		1				
23. 00	Pharmacy	0	1	0			23. 00
24. 00	Dental	0)	0			24. 00
25. 00	Optometry	0)	0			25. 00
25. 01	Tel eheal th	0)	0			25. 01
25. 02	Chronic Care Management	0)	0			25. 02
26. 00	All other nonreimbursable costs	0)	0			26. 00
27. 00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0		0			28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	29,	776			29. 00
30.00	Administrative Costs	-352	97,	850			30.00
31.00	Total Facility Overhead (sum of lines 29 and	-352	127,	626			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-352	327,	611			32.00
	and 31)						

	Financial Systems	CARLE EUREKA				eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der CC		Period: From 01/01/2023	Worksheet M-2	
			Component (To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col.	
		1. 00	2.00	3.00	4, 00	5. 00	
	VISITS AND PRODUCTIVITY	1					
	Posi ti ons						1
1. 00	Physi ci an	3. 31	15, 502	4, 200	13, 902		1.00
2. 00	Physici an Assistant	0. 44	0	2, 100	924		2.00
3. 00	Nurse Practitioner	0. 43	0	2, 100	903		3.00
4. 00	Subtotal (sum of lines 1 through 3)	4. 18	15, 502		15, 729	15, 729	4.00
5. 00	Visiting Nurse	0.00	0			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
3. 00	Total FTEs and Visits (sum of lines 4	4. 18	15, 502			15, 729	8.00
0 00	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	', line 22)			2, 508, 209	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	18)			0	11.00
12.00	00 Cost of all services (excluding overhead) (sum of lines 10 and 11)						12.00
13. 00	No Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						13.00
14.00							14.00
15. 00							15.00
16. 00						2, 231, 631	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					2, 231, 631	
	Overhead applicable to hospital-based RHC/FC					2, 231, 631	19.00
20 00	Total allowable cost of hospital-based RHC/F	OHC services (s	um of lines 10	and 19)		4, 739, 840	1 20 00

	Financial Systems	CARLE EUREKA				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 5/29/2024 8:5	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel			(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. 45					1.00
2.00	Physician Assistant	0. 84					2. 00
3.00	Nurse Practitioner	0. 00		_,			3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 29			3, 654	5, 445	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	l .			0	1
7. 01 7. 02	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
7. 03	Marriage and Family Therapist						7. 03
7. 03	Mental Health Counselor						7. 03
8. 00	Total FTEs and Visits (sum of lines 4	1. 29	5, 445			5, 445	
0.00	through 7)	1.27	0, 110			0, 110	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPITAL-BASE	ED RHC/FOHC SER	VICES		1. 00	
10.00				V1 023		794, 853	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	1
12. 00	Cost of all services (excluding overhead) (si					794, 853	
13.00							13. 00
14.00	00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						14. 00
15.00							15. 00
16.00		- '	•			703, 083	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					703, 083	
	Overhead applicable to hospital-based RHC/FQ					703, 083	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		1, 497, 936	20.00

	Financial Systems	CARLE EUREKA				u of Form CMS-2	
LLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co	CN: 14-1309	Period: From 01/01/2023	Worksheet M-2	
			Component (To 12/31/2023	Date/Time Pre	pared
						5/29/2024 8:5	
					RHC III	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)			
		1. 00	2.00	3.00	3) 4. 00	4 5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Posi ti ons						1
00	Physi ci an	0.00	0		0		1.0
00	Physician Assistant	0.00	0		0 0		2. (
00	Nurse Practitioner	0.88	850		-		3.
00	Subtotal (sum of lines 1 through 3)	0.88	850	2, 10	1, 848		
00	Visiting Nurse	0.00	0.00		1,010	0	1
00	Clinical Psychologist	0. 00	0			0	
00	Clinical Social Worker	0.00	0			0	1
01	Medical Nutrition Therapist (FQHC only)	0. 00	0			0	7.
)2	Diabetes Self Management Training (FQHC	0. 00	0			0	7.
	only)						
03	Marriage and Family Therapist						7.
04	Mental Health Counselor						7.
00	Total FTEs and Visits (sum of lines 4	0. 88	850			1, 848	8.
	through 7)						
00	Physician Services Under Agreements		0			0	9.
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL BASE	D RHC/FOHC SER	VICES		1.00	
00	Total costs of health care services (from V			V1 020		199, 985	10
00	Total nonreimbursable costs (from Wkst. M-1		. ,			0	
00	Cost of all services (excluding overhead) (199, 985	
00	Ratio of hospital -based RHC/FQHC services (1.000000	
00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						127, 626	
00	Parent provider overhead allocated to facil			,		124, 229	
00	Total overhead (sum of lines 14 and 15)		•			251, 855	16.
00	Allowable GME overhead (see instructions)					0	17.
00	Enter the amount from line 16					251, 855	
. 00	Overhead applicable to hospital-based RHC/F	FQHC services (li	ne 13 x line 1	8)		251, 855	19.
00	Total allowable cost of hospital-based RHC/	/FNHC services (s	um of lines 10	and 10)		451, 840	20

	Financial Systems CARLE EUREKA H ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1309	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (Component CCN: 14-8581	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:5	pared:
		Title XVIII	RHC I	Cost	<u>.</u>
				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)		4, 739, 840	1.00
2.00	Cost of injections/infusions and their administration (from W	kst. M-4, line 15)		312, 235	
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		4, 427, 605	
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 9)		15, 729 0	
6. 00	Total adjusted visits (line 4 plus line 5)	7,		15, 729	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			281. 49	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	295. 11	8. 00
9. 00	Rate for Program covered visits (see instructions)		0.00	281. 49	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	0	4, 470	l 10. 00
11. 00	Program cost excluding costs for mental health services (line		0	1, 258, 260	
12.00	Program covered visits for mental health services (from contra		0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x li	•	0	0	13.00
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instructions		0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	1, 258, 260	
16. 01	Total program charges (see instructions)(from contractor's re-	•		1, 592, 212	
16. 02	Total program preventive charges (see instructions) (from provi			0	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0)			0 917, 390	16. 03 16. 04
	(Titles V and XIX see instructions.)	o and 10, 11 mes 100,		717, 676	
16. 05	Total program cost (see instructions)		0	917, 390	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 111, 522	
18.00	records)	(11 oiii coitti actoi		111, 522	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		263, 494	19. 00
20.00	Net program cost excluding injections/infusions (see instruct	•		917, 390	
21. 00 21. 50	Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions)	M-4, line 16)		98, 642	21. 00 21. 50
21. 55	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, 1	minus line 21.60)		1, 016, 032	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			359 233	1
24. 00	1 *	ructions)		233	1
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25. 00
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 1, 016, 265	
26. 01	Sequestration adjustment (see instructions)			20, 325	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
	Interim payments Tentative settlement (for centractor use only)			849, 311	
28. 00 29. 00	,	ກາງ 27 and 28)		0 146, 629	
_ /. 00	Protested amounts (nonallowable cost report items) in accordan	· · · · · · · · · · · · · · · · · · ·		140, 027	1

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED	E EUREKA HOSPITAL RHC/FQHC Provider C	CN: 14-1309	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES	Component	CCN: 14-8582	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
	Title	XVIII	RHC II	Cost	
				1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SE					
1.00 Total Allowable Cost of hospital-based RHC/FQHC Serv				1, 497, 936	
2.00 Cost of injections/infusions and their administratio 3.00 Total allowable cost excluding injections/infusions		ne 15)		70, 098 1, 427, 838	
4.00 Total Visits (from Wkst. M-2, column 5, line 8)	(11110 1 11111100 111110 2)			5, 445	1
5.00 Physicians visits under agreement (from Wkst. M-2, c	column 5, line 9)			0	
6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)				5, 445 262. 23	
7.00 Majusted cost per visit (Time 3 divided by Time 0)			Cal cul ati on		7.00
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1. 00	12/31/2023) 2. 00	
8.00 Per visit payment limit (from CMS Pub. 100-04, chapt	er 9, §20.6 or your c	ontractor)	0.00		8. 00
9.00 Rate for Program covered visits (see instructions)		·	0.00		1
CALCULATION OF SETTLEMENT 10.00 Program covered visits excluding mental health servi	cas (from contractor	records)	0	1, 811	10.00
11.00 Program cost excluding costs for mental health servi	,	,	0	474, 899	
12.00 Program covered visits for mental health services (f		s)	0	0	
13.00 Program covered cost from mental health services (li 14.00 Limit adjustment for mental health services (see ins			0	0	
15.00 Graduate Medical Education Pass Through Cost (see in	,		0	O	15. 00
16.00 Total Program cost (sum of lines 11, 14, and 15, col	umns 1, 2 and 3) *		0	474, 899	1
16.01 Total program charges (see instructions)(from contra 16.02 Total program preventive charges (see instructions)(•	dc)		460, 233	1
16.02 Total program preventive charges (see instructions)(16.03 Total program preventive costs ((line 16.02/line 16.		us)		0	
16.04 Total Program non-preventive costs ((line 16 minus I		mes .80)		355, 204	
(Titles V and XIX see instructions.) 16.05 Total program cost (see instructions)			0	355, 204	16. 05
17.00 Primary payer amounts			0	355, 204	1
18.00 Less: Beneficiary deductible for RHC only (see inst	ructions) (from contr	actor		30, 894	18.00
records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see i	nstructions) (from co	ntractor		79, 602	19.00
records)	nstructions) (rrom co	iiti dotoi		77,002	17.00
20.00 Net program cost excluding injections/infusions (see		()		355, 204	1
21.00 Program cost of vaccines and their administration (f 21.50 Total program IOP OPPS payments (see instructions)	rom WKST. M-4, line i	6)		20, 110	21.00
21. 55 Total program IOP Costs (see instructions)					21. 55
21.60 Program IOP deductible and coinsurance (see instruct	•	4 (0)		075 044	21.60
22.00 Total reimbursable Program cost (sum of lines 20, 21 23.00 Allowable bad debts (see instructions)	, 21.50, minus line 2	1. 60)		375, 314 0	1
23.01 Adjusted reimbursable bad debts (see instructions)				0	1
24.00 Allowable bad debts for dual eligible beneficiaries	(see instructions)			0	
25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 25.50 Pioneer ACO demonstration payment adjustment (see in	nstructions)			0	
25.99 Demonstration payment adjustment amount before seque	,			0	
26.00 Net reimbursable amount (see instructions)				375, 314	
26.01 Sequestration adjustment (see instructions)26.02 Demonstration payment adjustment amount after seques	stration			7, 506 0	1
27. 00 Interim payments				392, 997	
28.00 Tentative settlement (for contractor use only)		00)		0	
29.00 Balance due component/program (line 26 minus lines 2 30.00 Protested amounts (nonallowable cost report items) i		•		-25, 189 0	
chapter I, §115.2	ii accordance with the	1 up. 15-11,] 30.00

	Financial Systems CARLE EUREKA H ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1309	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C	ES	Component CCN: 14-8620	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 8:5	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			451, 840	1.00
2. 00 3. 00	Cost of injections/infusions and their administration (from WI Total allowable cost excluding injections/infusions (line 1 m			8, 303 443, 537	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	rnus rrne zj		1, 848	•
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			1, 848 240. 01	6. 00 7. 00
7.00	Hajustea cost per visit (iiile 3 arvidea by iiile 0)		Cal cul ati on		7.00
				D D 1	
			Rate Period N/A	Rate Period 1 (01/01/2023	
			10771	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. 00 222. 18	8. 00
9. 00	Rate for Program covered visits (see instructions)		0. 00	222. 18	•
10.00	CALCULATION OF SETTLEMENT			1.40	1 40 00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	*	0	149 33, 105	•
12. 00	Program covered visits for mental health services (from contra	•	0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x li		0	0	13.00
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instructions	,	0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	33, 105	•
16. 01	Total program charges (see instructions)(from contractor's re	*		39, 570	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		0	16. 02 16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0)	•		23, 360	1
4	(Titles V and XIX see instructions.)			00.040	4, 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	23, 360 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		3, 905	•
40.00	records)) (G			40.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		6, 098	19. 00
20.00	Net program cost excluding injections/infusions (see instruct	i ons)		23, 360	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		3, 159	1
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	Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus line 21.60)		26, 519	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	1
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction: Demonstration payment adjustment amount before sequestration	s)		0	25. 50 25. 99
26. 00	Net reimbursable amount (see instructions)			26, 519	
26. 01	Sequestration adjustment (see instructions)			530	
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 62, 166	26. 02 27. 00
28. 00				02, 100	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	•		-36, 177	29. 00
30.00	Protested amounts (nonallowable cost report items) in accordal chapter I, §115.2	nce with CMS Pub. 15-II,		0	30.00

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 5/29/2024 8:5	
		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	
. 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	2, 439, 778 0. 004900	2, 439, 77 0. 01470			
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	11, 955	35, 86	10, 247	0	3. 0
. 00	Injections/infusions and related medical supplies costs (from your records)	68, 963	38, 19		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)	80, 918 2, 508, 209	74, 06 2, 508, 20		0 2, 508, 209	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)	2, 231, 631 0. 032261	2, 231, 63 0. 02952		2, 231, 631 0. 000000	7. (8. (
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)	71, 995 152, 913	65, 89 139, 95			
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	368 415. 52 118	1, 10 126. 7 37	77 60. 13		
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)	49, 031	46, 90	2, 706		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.	M-3, line 2)			312, 235	
6. 00	Total Program cost of injections/infusions and their admin	istration costs	(sum of		98, 642	16.

	Financial Systems CARLE EUREK ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC	:N: 14-1309	Peri od:	u of Form CMS-2 Worksheet M-4	
	Wilder to the Brook wilder wilder in the brook	Component C		From 01/01/2023 To 12/31/2023	Date/Time Pre	
		Component	CN. 14-0502	10 12/31/2023	5/29/2024 8:5	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCINES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY	
		VACCINES	VACCINES	VACCINES	PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	772, 084	772, 08		772, 084	
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 007170	0. 01530	0. 000000	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	5, 536	11, 81	0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	14, 242	5, 60		0	4. 00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	19, 778	17, 41		0	5. 00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	794, 853	794, 85		794, 853	6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	703, 083	703, 08		703, 083	
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 024883	0. 02191		0. 000000	
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	17, 495	15, 40		0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	37, 273	32, 82		0	
11.00	Total number of injections/infusions (from your records)	76	16		0	
12.00	Cost per injection/infusion (line 10/line 11)	490. 43	202. 6			12. 00 13. 00
13. 00	Number of injection/infusion administered to Program beneficiaries	22	2	16 20	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their	10, 789	9, 32	21 0	0	14. 00
	administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)					
	and 13.01, as appricable)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
15 00	Total cost of injections/infusions and their administration	n costs (sum of	columns 1	1. 00	2. 00 70, 098	15. 00
13.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		70,090	15.00
16 00	Total Program cost of injections/infusions and their admini	istration costs	(sum of		20, 110	16 00

OMPU	TATION 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 Prep 5/29/2024 8:59	
		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	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	193, 963 0. 002100	193, 96 0. 00470		193, 963 0. 000000	1
. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	407	91	136	0	3.
. 00	Injections/infusions and related medical supplies costs (from your records)	346	1, 87	74 0	0	
. 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)	753 199, 985	2, 78 199, 98			5. 6.
. 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)	251, 855 0. 003765	251, 85 0. 01393		251, 855 0. 000000	
. 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)	948 1, 701	3, 50 6, 29		0 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	12 141. 75 2	233. 1	27 4 15 76. 75 12 1	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)	284	2, 79	98 77		14.
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		8, 303	15.
5 00	Total Program cost of injections/infusions and their admin		(sum of		3, 159	16

Health Financial Systems	CARLE EUREKA H	OSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 14-1309 Component CCN: 14-8581	From 01/01/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:55 pm

				5/29/2024 8: 55	5 pm
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00 884, 891	
	Total interim payments paid to hospital-based RHC/FQHC	al interim payments paid to hospital-based RHC/FQHC			1.
	Interim payments payable on individual bills, either submitted or to be submitted to			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
_	Program to Provider			_	_
01				0	3
02				0	3
03				0	3
04				0	3
05				0	3
	Provider to Program		00 (05 (0000	05.500	_
50			09/05/2023	35, 580	3
51				0	3
52				0	3
53				0	3
54		99)		0	3
- 1	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.4	•		-35, 580	3
	Total interim payments (sum of lines 1, 2, and 3.99) (trans [.] 27)	rer to worksheet M-3, line		849, 311	4
	O BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after des	k raviaw Also show data of			5
	each payment. If none, write "NONE" or enter a zero. (1)	K Teview. Also show date of			J
	Program to Provider				
01	rogiam to rrovider			0	5
02				o	5
03				0	5
Р	Provider to Program		•	•	
50				0	5
51				0	5
52				0	5
99 9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
	Determined net settlement amount (balance due) based on the	cost report. (1)			6
	SETTLEMENT TO PROVIDER	•		146, 629	6
)2 5	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			995, 940	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00		NATIONAL GOVERNMENT SERVICES	06101		8.
		I NC.			

Health Financial Systems	CARLE EUREKA H	OSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 14-1309 Component CCN: 14-8582	From 01/01/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:55 pm

		Component CCN: 14-8582	0 12/31/2023	5/29/2024 8:55	
			RHC II	Cost	э рііі
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2, 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			406, 950	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2. 00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 01
3. 02				0	3. 02
3. 03				0	3. 03
3.04				0	3. 04
3. 05				0	3. 05
2 50	Provider to Program		00 (05 (2022	12.052	2 50
3.50			09/05/2023	13, 953	3. 50
3.51				0	3. 51
3. 52 3. 53				0	3. 52 3. 53
3. 53 3. 54				0	3. 53 3. 54
3. 54 3. 99	 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)		-13, 953	3. 54 3. 99
3. 99 4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			392, 997	3. 99 4. 00
4.00	27)	ster to worksheet M-3, Title		372, 777	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date of			5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5. 01
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5. 50				0	5. 50
5. 51				0	5. 51
5. 52		993		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6. 00
6. 01	SETTLEMENT TO PROVIDER			0 05 100	6. 01
6. 02	SETTLEMENT TO PROGRAM			25, 189	
7. 00	Total Medicare program liability (see instructions)		0 1 1	367, 808	7. 00
			Contractor	NPR Date	
		0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	NATIONAL GOVERNMENT SERVICES		2.00	8. 00
5. 00		I NC.	00101		0.00
	I e e e e e e e e e e e e e e e e e e e	!	1		

Health Financial Systems	CARLE EUREKA HO	SPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE	S	Provider CCN: 14-1309 Component CCN: 14-8620	From 01/01/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:55 pm

		Component Con. 14-8020	10 12/31/2023	5/29/2024 8: 55	
			RHC III	Cost	- p
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC	-		36, 671	1. 00
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01			09/05/2023	25, 495	3.0
3. 02				0	3. 02
3. 03				0	3. 03
3. 04				0	3. 04
3. 05				0	3. 0!
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 5
3.53				0	3. 5
3.54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			25, 495	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		62, 166	4. 00
	27)				
F 00	TO BE COMPLETED BY CONTRACTOR		6		F 0/
5. 00	List separately each tentative settlement payment after des	sk review. Also show date of	Г		5. 0
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
5. 01	Program to Provider			1 0	5. 0
5. 02					5. 0
5. 02					5. 0
5. 05	Provider to Program				5. 0.
5. 50	Trovince to Frogram			0	5. 50
5. 51				0	5. 5
5. 52				0	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 9
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)				6. 0
6. 01	SETTLEMENT TO PROVIDER			o	6. 0
6. 02	SETTLEMENT TO PROGRAM			36, 177	6. 0
7. 00	Total Medicare program liability (see instructions)			25, 989	7. 0
	1 13 1 13 13 13 13 13 13 13 13 13 13 13		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8. 00	Name of Contractor				8. 00
	·	·	*		