This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0191 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 4:15 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2023 4: 15 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] Initial 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 Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(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 FRANCISCAN BEACON HOSPITAL (15-0191) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	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	CF0			3
4	Date				4

			Ti tle XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-1, 233	11, 732	0	37, 520	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	-1, 233	11, 732	0	37, 520	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 FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0191 Peri od: Worksheet S-2 From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/30/2023 4:15 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 1010 W. STATE ROAD 2 PO Box: 1.00 State: IN County: LA PORTE 2.00 City: LAPORTE Zip Code: 46350 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN BEACON 150191 33140 03/24/2021 Ν 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

22.04

23 00

3

N

Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

Which method is used to determine Medicaid days on lines 24 and/or 25

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

22.04 Did this hospital receive a geographic reclassification from urban to

23 00

yes or "N" for no.

yes or "N" for no.

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

58.00

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0191 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 4: 15 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). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program 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

Health Financial Systems	FRANCI SO	CAN BEACON HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider CO		riod: com 01/01/2022 12/31/2022	Worksheet S-2 Part I Date/Time Prep 5/30/2023 4:1	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Year			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	ry trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio instructions)	0. 00	0. 00		64. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	0.00	0. 00		65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-primar ccurring in all nonpr unweighted non-primar	rovider settings. Ty care resident	0.00	0. 00	0. 000000	66. 00
(column 1 divided by (column 1 +	column 2)). (see ins Program Name	structions) Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4.00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	67. 00

	FINANCISCAN BEACON HOSPITAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider (CCN: 15-0191	Peri od: From 01/01/20 To 12/31/20		epared:			
				1.00				
8. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-4 For a cost reporting period beginning prior to October 1, 2022, did you a MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fin	obtain permiss	sion from your	N	68. 00			
			1	. 00 2. 00 3. 00				
2 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it con	tain an IDE si	ıhnrovi der?	N	70.00			
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachirecent cost report filed on or before November 15, 2004? Enter "Y" for yes 2004 this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yolumn 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	ing program ir yes or "N" for s in a new tea yes or "N" for	n the most no. (see aching no.	0	71.00			
5. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it of	contain an IRF	=	N	75.00			
6. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: In indicate which program year began during this cost reporting period. (see	r "Y" for yes m in accordand f column 2 is	or "N" for ce with 42 Y,	0	76. 00			
				1.00				
0. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for			N	80. 00 81. 00			
	0 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N "Y" for yes and "N" for no. TEFRA Providers							
	00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							
7. 00	Is this hospital an extended neoplastic disease care hospital classified 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section	١	N	87.00			
			Approved for Permanent Adjustment (Y/N)	Approved				
8. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEI amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete (89. (see instructions)				0 88.00			
	Column 2: Enter the number of approved permanent adjustments.	Wkst Alir	ne Effective Da	ate Approved				
		No.	ie Errective be	Permanent Adjustment Amount Per Discharge				
9. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00	3.00	0 89.0			
7. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	0.			07.00			
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.							
			V 1. 00	XI X 2. 00				
0. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? I	Enter "Y" for	N	Υ	90.0			
1. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost repo		N	Υ	91.00			
2. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column Are title XIX NF patients occupying title XVIII SNF beds (dual certifica			N	92.00			
3. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V an	nd XIX? Enter	N	N	93. 0			
	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for ı	no in the	N	N	94. 0			
4. 00 5. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable colum Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.		0. 00 N	0. 00 N	95. 00 96. 00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCM	N: 15-0191	Period: From 01/01/2022 To 12/31/2022		2 epared:		
			V	XI X	J piii		
98.00 Does title V or XIX follow Medicare (title XVIII) for the in	nterns and resid	dents nost	1. 00 N	2.00 N	98. 0		
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the re	for yes or "N" 1	for no in		Y	98. 0		
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tititle XIX.		Y	98.0				
	O2 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX.						
P8.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.			1 N	N	98. 0		
Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 0		
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98. 0		
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in						
Rural Providers 105.00 Does this hospital qualify as a CAH?			N	I	105. 0		
106.00 If this facility qualifies as a CAH, has it elected the all-	inclusive metho	od of paymen			106. 0		
for outpatient services? (see instructions)	set roimburcomor	at for I&D			107. 0		
training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do	7.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?						
108.00 Is this a rural hospital qualifying for an exception to the		ul e? See 42	N		108. 0		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	I Speech	Respi ratory			
100 00 0 1 1 1 1 1 1 1	1.00	2.00	3.00	4.00	100.0		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 0		
				1.00	-		
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes or '	"N" for no.	lf yes,	N	110. 0		
			1. 00	2.00	-		
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co		eriod? Enter	N	2.00	111. 0		
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	olumn 1 is Y, er ticipating in o	column 2.					
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad	olumn 1 is Y, er ticipating in o	column 2.	2.00	3.00			
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea	olumn 1 is Y, erticipating in olditional beds; th Model exporting olumn 1 is pating in the	column 2. and/or "C"	2.00	3.00	112. 0		
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.	olumn 1 is Y, erticipating in olditional beds; th Model eporting olumn 1 is pating in the ased	and/or "C"	2.00	3.00			
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	olumn 1 is Y, erticipating in olditional beds; th Model exporting olumn 1 is parting in the ased as and Rural cost "N" for no 3, or E only) 3" percent (includes)	and/or "C"	2.00		113. 0		
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	th Model porting in the search of the Model porting olumn 1 is parting in the search of the model porting in the search of the model porting in the search of the model porting in the model porting i	2. and/or "C" 1.00 N	2.00		112. 0 113. 0 0 115. 0		
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	th Model eporting of the model eporting of t	2. and/or "C" 1. 00 N	2.00		113. C		
"Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	th Model porting the Model porting blumn 1 is Y, er ticipating in or dditional beds; th Model porting blumn 1 is pating in the ased s and Rural cost "N" for no s, or E only) 23" percent (includes (s) based on for yes or rance? Enter	2. and/or "C" 1. 00 N	2.00		113. c		

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	FRANCISCAN BEACON	N HOSPITAL Provider CCM	N: 15-0191 P	In Lie	u of Form CM Worksheet S	
				rom 01/01/2022 o 12/31/2022	Part I Date/Time F	
			Premi ums	Losses	5/30/2023 4 I nsurance	
			1 00	2.00	2.00	
118.01 List amounts of malpractice premiums and	paid Losses:		1. 00 1	2.00	3. 00	0 118. 01
				1. 00	2. 00	
118.02 Are mal practice premiums and paid losses Administrative and General? If yes, submand amounts contained therein.	reported in a cost control it supporting schedul	enter other the e listing cos	han the st centers	N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for \$3121 and applicable amendments? (see ins "N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 and Enter in column 2, "Y" for yes or "N" for	structions) Enter in o n < 100 beds that qual applicable amendments	column 1, "Y" ifies for the	for yes or e Outpatient	N	N	119. 00 120. 00
121.00 Did this facility incur and report costs patients? Enter "Y" for yes or "N" for no		table devices	charged to	N		121. 00
122.00 Does the cost report contain healthcare r Act?Enter "Y" for yes or "N" for no in co	elated taxes as defir Dlumn 1. If column 1 i			N		122. 00
the Worksheet A line number where these 1 123.00 Did the facility and/or its subproviders services, e.g., legal, accounting, tax pr management/consulting services, from an u for yes or "N" for no.	(if applicable) purch eparation, bookkeepin	ng, payroll, a	and/or			123. 00
If column 1 is "Y", were the majority of professional services expenses, for servilocated in a CBSA outside of the main hos "N" for no.	ces purchased from ur	nrelated orgai	ni zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-cer	tified transplant cer	nter? Enter "'	Y" for ves	N		125. 00
and "N" for no. If yes, enter certificati 126.00 If this is a Medicare-certified kidney tr	on date(s) (mm/dd/yyy	yy) below.	,			126. 00
in column 1 and termination date, if appl	icable, in column 2.					
127.00 f this is a Medicare-certified heart tra in column 1 and termination date, if appl	icable, in column 2.					127. 00
128.00 If this is a Medicare-certified liver train in column 1 and termination date, if appl		er the certifi	ication date			128. 00
129.00 If this is a Medicare-certified lung tran in column 1 and termination date, if appl		the certific	cation date			129. 00
130.00 If this is a Medicare-certified pancreas date in column 1 and termination date, if	transplant program, e		ti fi cati on			130. 00
131.00 If this is a Medicare-certified intestina	ıl transplant program,	enter the c	erti fi cati on			131. 00
date in column 1 and termination date, if 132.00 If this is a Medicare-certified islet tra			ication date			132. 00
in column 1 and termination date, if appl 133.00 Removed and reserved	icable, in column 2.					133. 00
134.00 If this is a hospital-based organ procure in column 1 and termination date, if appl ALL Providers		PO), enter the	e OPO number			134. 00
140.00 Are there any related organization or hom chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home of	no in column 1. If ye	es, and home o	office costs	N		140. 00
1.00 If this facility is part of a chain organ home office and enter the home office con	2.00 nization, enter on lin	nes 141 throu	gh 143 the na	3.00 me and address	of the	
141. 00 Name: Co	ntractor's Name:	tractor numbe		's Number:		141. 00
· · · · · · · · · · · · · · · · · · ·	Box: ate:		Zi p Code:			142. 00 143. 00
144.00 Are provider based physicians' costs incl	uded in Worksheet A?				1. 00 Y	144. 00
				1. 00	2.00	
145.00 If costs for renal services are claimed of inpatient services only? Enter "Y" for yearno, does the dialysis facility include Meperiod? Enter "Y" for yes or "N" for no	es or "N" for no in co edicare utilization fo	olumn 1. If co	olumn 1 is			145. 00
146.00 Has the cost allocation methodology change Enter "Y" for yes or "N" for no in column yes, enter the approval date (mm/dd/yyyy)	yed from the previousl n 1. (See CMS Pub. 15-			N		146. 00

Health Financial Systems	FRANCISCAN BE	EACON HOSPITAL		In l	ieu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	CN: 15-0191	Period: From 01/01/20 To 12/31/20		repared:
					1.00	
147.00 Was there a change in the statist	cal hasis? Enter "V" for	ves or "N" for	no		1.00 N	147. 00
148.00 Was there a change in the order of					N N	148. 00
149.00 Was there a change to the simplif				or no.	N N	149. 00
, , , , , , , , , , , , , , , , , , ,		Part A	Part B		Title XIX	
		1.00	2. 00	3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or					413. 13)	
155. 00 Hospi tal		N	N N	N	N	155. 00
156.00 Subprovider - IPF		N	N	N	N	156. 00
157.00 Subprovi der - IRF		N	N	N	N	157. 00
158. 00 SUBPROVI DER		N.	l N	N.	N.	158. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N	N N	N N	159. 00 160. 00
161.00CMHC		IN	N N	N N	N N	161. 00
TOT. OO CWITE			I IV	10		101.00
M I ±					1.00	
Multicampus 165.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no.	ampus hospital that has c	one or more campu	uses in diff	ferent CBSAs?	N	165. 00
Enter 1 for yes of N for no.	Name	County	State 2	Zip Code CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00 4.00		
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.	00 166. 00
					1.00	_
Health Information Technology (HI	T) incentive in the Ameri	can Recovery and	d Reinvestm	ent Act	1.00	
167.00 Is this provider a meaningful use				CITE AGE	Υ	167.00
168.00 If this provider is a CAH (line 1) reasonable cost incurred for the	05 is "Y") and is a meani	ngful user (line		'), enter the		168. 0
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, do	oes this provider				168. 0
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") ar				ne 0.	00169. 0
,				Begi nni ng	Endi ng	
				1. 00	2.00	
<pre>170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)</pre>	peginning date and ending	g date for the re	eporti ng			170. 0
				1. 00	2.00	+
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, Pt umn 1. If column 1 is yes	I. I, line 2, col	. 6? Enter	N		0 171. 00

Heal th	Financial Systems FRANCISCAN BEA	ACON HOSPITAL		In lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0191	Peri od:	Worksheet S-2	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	
				Y/N	5/30/2023 4: 1 Date	5 pm
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N			or all dates in	tho.	-
	mm/dd/yyyy format.	viol all Noie	sponses. Lift	er arr dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see			\/ /I	
			1.00	2. 00	V/I 3. 00	
2.00	Has the provider terminated participation in the Medicare I		N			2. 00
	yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	nn 3, V for				
3.00	Is the provider involved in business transactions, including	ng management	N			3. 00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members	of the board				
	of directors through ownership, control, or family and other relationships? (see instructions)	er similar				
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prepared by a Cer		N			4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differenthose on the filed financial statements?		N			5. 00
	those on the fired financial statements: If yes, submit fee	CONCITTATION.		Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6.00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provide	r N	I	6. 00
7.00	the legal operator of the program?	+	·	N		7.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ved during th	e N		7. 00 8. 00
0.00	cost reporting period? If yes, see instructions.		G			0.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated		he current	N		10. 00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	I & R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.) (n)	
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 00 13. 00
	period? If yes, submit copy.					
14. 00	If line 12 is yes, were patient deductibles and/or coinsural instructions.	ance amounts wa	nived? If yes	, see	N	14. 00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporti		yes, see ins t A		│ N rt B	15. 00
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only?	Υ	04/28/2023	Y	04/28/2023	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 totals and the provider's records for allocation? If	N		N		17. 00
	either column 1 or 3 is yes, enter the paid-through date					
10.00	in columns 2 and 4. (see instructions)	N		N		10.00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	I	I	I	I

Heal th	Financial Systems FRANCISCAN BEA	ACON HOSPITAL		In Lie	u of Form CM	S-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider 0	CCN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part II Date/Time F 5/30/2023 4	repared:		
		Descr	i pti on	Y/N	Y/N			
			0	1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EDT CHILDDENS I	LOCDI TAL C)		1.00			
	Capital Related Cost	LFI CIIILDKLING I	IUSFI TALS)					
22. 00	Have assets been relifed for Medicare purposes? If yes, se	o instructions				22, 00		
23. 00	Have changes occurred in the Medicare depreciation expense			sing the cost		23. 00		
23.00		uue to apprais	sais illaue uui	ing the cost		23.00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into during	this cost re	eporting period?		24. 00		
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rting period′	? If yes, see		25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ing period?	If yes, see		26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during th	·	0 .	•		27. 00		
27.00	сору.	e cost reporti	ig perrou: i	yes, subiii t		27.00		
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit e</pre>	ntered into du	ring the cos	t reporting		28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	hand funds (De	aht Sarvica I	Pasarva Fund)		29. 00		
	treated as a funded depreciation account? If yes, see inst	ructi ons		•				
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	urity with new	debt? If yes	s, see		30.00		
31. 00								
	Purchased Services							
32.00	Have changes or new agreements occurred in patient care se	rvices furnish	ed through co	ontractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to compoti	itivo bidding2 lf		33. 00		
33.00	no, see instructions.	pried pertaini	ng to competi	tive brading: II		33.00		
	Provi der-Based Physi ci ans							
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-l	pased physicians?		34. 00		
	If yes, see instructions.							
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based		35. 00		
				Y/N	Date			
				1. 00	2.00			
	Home Office Costs							
	Were home office costs claimed on the cost report?					36. 00		
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office	?		37. 00		
38. 00	If line 36 is yes , was the fiscal year end of the home of			f		38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			5,		39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes. see			40. 00		
	instructions.	1	. ,			13.33		
		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,	TI NA		SEVERS		41.00		
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42. 00		
	preparer.		-	TOEVEDO OD HEAV	DCO COM			
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEAN	DCO. COM	43. 00		

Health Financial Systems FRANCISCAN	BEACON HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0191	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 4:1	pared:
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	MANAGER			41. 00
held by the cost report preparer in columns 1, 2, and 3,				
respectively.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cos	:			43.00
report preparer in columns 1 and 2, respectively.				

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 |

				'	0 12/31/2022	5/30/2023 4:1	
						I/P Days / 0/P	D PIII
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH 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	3	2, 920	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		}	2, 920	0. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY			2 020	0.00		13.00
14. 00 15. 00	Total (see instructions) CAH visits		8	2, 920	0.00	0	14. 00 15. 00
16. 00	SUBPROVI DER - I PF					U	16. 00
17. 00	SUBPROVIDER - IPF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		8	3			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)		(ol c)		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	(o) c)	0	34.00

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/30/2023 4:15 pm	

						5/30/2023 4: 1	5 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA			•		•	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	51	10	114			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)	0	0				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6. 00
7.00	Total Adults and Peds. (exclude observation	51	10	114			7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE 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		4.0				13.00
14. 00	Total (see instructions)	51	10			32. 21	
15. 00	CAH visits	0	0	C			15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00 19. 00	SUBPROVI DER						18. 00 19. 00
20. 00	SKILLED NURSING FACILITY 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)			d			24. 10
25. 00	CMHC - CMHC			Ĭ			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
27. 00	Total (sum of lines 14-26)	J	· ·		0.00		1
28. 00	Observation Bed Days		0	64			28. 00
29. 00	Ambul ance Trips	0					29. 00
30. 00	Employee discount days (see instruction)			C			30. 00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)	0	0	C			32. 00
32. 01	Total ancillary labor & delivery room]					32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	[c			34. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 |

				10) 12/31/2022	5/30/2023 4:1	
		Full Time	_	Di sch	arges	07 007 2020 11 1	J
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	26	4	49	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)			0	0		2.00
3. 00	HMO and other (see instructions) HMO IPF Subprovider			U	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 SNI						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	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	26	4	49	14. 00
15.00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			o			33. 00
33. 00	LTCH non-covered days LTCH site neutral days and discharges			0			33. 00
	Temporary Expansi on COVID-19 PHE Acute Care						34. 00
51.50	Tomporary Expansion out to 17 The Moute out	ı I			'		1 3 1. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To

					T	12/31/2022	Date/Time Pre 5/30/2023 4:1	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3.00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	3, 149, 143	0	3, 149, 143	66, 999. 00	47. 00	1.00
2. 00	instructions) Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2.00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3.00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	1	0	0. 00 0. 00	l .	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6.00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	О	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0		0	0. 00 0. 00	l .	
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		0	_		0.00		
12. 00	Contract labor: Top level management and other management and administrative services		8, 750	0	8, 750	22. 00	397. 73	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0. 00	13.00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14. 01	Home office salaries		0	1	1	0.00	l .	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A - Administrative		0	1	0	0. 00 0. 00	l .	
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0.00	16.00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see instructions)		619, 990	0	619, 990			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		0		0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

| Period: | Worksheet S-3 | From 01/01/2022 | Part II | To | 12/31/2022 | Date/Time | Prepared:

					T	o 12/31/2022	Date/Time Prep 5/30/2023 4:1	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	, i	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		C	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	C	0	1	0. 00		26. 00
27. 00	Administrative & General	5. 00	C	167, 618				27. 00
28. 00	Administrative & General under		C	8, 750	8, 750	22. 00	397. 73	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	C	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	C	0	0	0. 00		
31. 00	Laundry & Linen Service	8. 00	C	0	0	0. 00		
32.00	Housekeepi ng	9. 00	C	0	0	0. 00		32.00
33. 00	Housekeeping under contract		C	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	C	0	0	0. 00		34. 00
35. 00	Dietary under contract (see		C	0	0	0. 00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	C	0	0	0. 00		36. 00
37. 00	Maintenance of Personnel	12. 00	C	0	0	0. 00		
38. 00	Nursing Administration	13. 00	C	0	0	0. 00		
39. 00	Central Services and Supply	14. 00	C) 0	0	0. 00		39. 00
40.00	Pharmacy	15. 00	C	0	0	0. 00		40. 00
41. 00	Medical Records & Medical	16. 00	C	0	0	0. 00	0. 00	41. 00
	Records Library							
42. 00	Soci al Servi ce	17. 00	C	0	0	0. 00		42. 00
43. 00	Other General Service	18. 00	C	0	0	0. 00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared: | Part | Part

					'	0 12/01/2022	5/30/2023 4: 1	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		3, 149, 143	8, 750	3, 157, 893	67, 021. 00	47. 12	1. 00
	instructions)							
2.00	Excluded area salaries (see		0	0	0	0.00	0. 00	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		3, 149, 143	8, 750	3, 157, 893	67, 021. 00	47. 12	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		8, 750	0	8, 750	22. 00	397. 73	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		619, 990	0	619, 990	0.00	19. 63	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		3, 777, 883	8, 750	3, 786, 633	67, 043. 00	56. 48	6. 00
7.00	Total overhead cost (see		0	176, 368	176, 368	9, 305. 00	18. 95	7. 00
	instructions)							

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0191	Peri od: Worksheet S-3 From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared:

	To 12/31/20	022 Date/Time Pre 5/30/2023 4:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	C	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	619, 900	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	0	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	. 0	16. 00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	0	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
20. 00	State or Federal Unemployment Taxes	0	20.00
	OTHER		_
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (s	see 0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	0	
24. 00	Total Wage Related cost (Sum of Lines 1 -23)	619, 900	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	l	25. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0191	From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/30/2023 4:15 pm

		10 12/31/2022	5/30/2023 4: 1	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	619, 900	1.00
2.00	Hospi tal	0	619, 900	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I	0	0	17.00
18. 00	0ther	0	0	18.00

	FAL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 15-0191	Peri od:	104 15 :	Worksheet S-1	0
				/01/2022	Data/Timo Dro	nara
			To 12	/31/2022	Date/Time Pre 5/30/2023 4:1	
					1. 00	
	Uncompensated and indigent care cost computation					4
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 col	umn 8)		0. 270075	1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid				29, 352	2.
00	Did you receive DSH or supplemental payments from Medicaid?				N 27, 002	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental page 1	ayments from Medi	i cai d?			4.
00	If line 4 is no, then enter DSH and/or supplemental payments from M	edi cai d			0	
00	Medi cai d charges				89, 035	1
00 00	Medicaid cost (line 1 times line 6)	7 minus sum of	linos 2 and	1 E. I.F	24, 046 0	
00	Difference between net revenue and costs for Medicaid program (line < zero then enter zero)	/ IIII IIus suiii 01	illies z alic	ı 5, II	0	'l °.
	Children's Health Insurance Program (CHIP) (see instructions for each	ch line)				
00	Net revenue from stand-alone CHIP				0	9.
. 00	Stand-alone CHIP charges				0	
. 00	Stand-alone CHIP cost (line 1 times line 10)	11! ! 0	: 6		0	1
. 00	Difference between net revenue and costs for stand-alone CHIP (line enter zero)	II minus iine 9	; ir < zero	tnen	0	12
	Other state or local government indigent care program (see instructi	ions for each li	ne)			
. 00	Net revenue from state or local indigent care program (Not included				0	13
. 00	Charges for patients covered under state or local indigent care projections.	gram (Not include	ed in lines	s 6 or	0	14
00	10)				0	1 1 -
. 00						15
. 00	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and	1 1 1 11 1 1	P 1	program	(-
		a state/rocar ind	αigent care	e pi ogi ali	is (see	
	instructions for each line)		digent care	e program		
	instructions for each line) Private grants, donations, or endowment income restricted to funding	g charity care	digent care	e program	0	
7. 00 8. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi	g charity care tal operations		. 0		18.
3. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi	g charity care tal operations		. 0	0	18.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind	g charity care tal operations igent care progra	ams (sum of	flines	0 0 0 Total (col. 1	18. 19.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind	g charity care tal operations igent care progra	ams (sum of	flines sured ients	0 0 0 Total (col. 1 + col. 2)	18. 19.
. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid , CHIP and state and local ind 8, 12 and 16)</pre>	g charity care tal operations igent care progra	ams (sum of	flines	0 0 0 Total (col. 1	18. 19.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind	g charity care tal operations igent care progra Uninsure patient 1.00	ams (sum of	flines sured ients	Total (col. 1 + col. 2) 3.00	18.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line)	g charity care tal operations igent care progra Uninsure patient 1.00	ams (sum of	flines sured ients	0 0 0 Total (col. 1 + col. 2)	18.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts	g charity care tal operations igent care progra Uninsure patient 1.00 y 3,812	ams (sum of	flines sured ients	Total (col. 1 + col. 2) 3.00	18 19
. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	g charity care tal operations igent care progrations in the second secon	ams (sum of led Ins pat 2	F lines sured i ents . 00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576	20.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	g charity care tal operations igent care progrations in the second secon	ams (sum of	Flines sured ients	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576	20.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	g charity care tal operations igent care progratient 1.00 y 3,812 (see 1,029 as 731	ams (sum of led Ins pat 2	F lines sured i ents . 00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576	20. 21. 22.
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	g charity care tal operations igent care progratient 1.00 y 3,812 (see 1,029 as 731	ams (sum of lns pat 2 , 181 , 575 , 381	F lines sured i ents . 00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576 731,381 298,195	20. 21. 22.
00 00 00 00 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	g charity care tal operations igent care progrations in the second secon	ams (sum of led Ins pat 2 2 , 181 , 575 , 381 , 194	F lines sured i ents . 00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576 731,381 298,195	20. 21. 22. 23.
00 00 00 00 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officiality care Cost of charity care (line 21 minus line 22)	g charity care tal operations igent care progrations in the second secon	ams (sum of led Ins pat 2 2 , 181 , 575 , 381 , 194	F lines sured i ents . 00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576 731,381 298,195	20. 21. 22. 23.
00 00 00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officiarity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care proglif line 24 is yes, enter the charges for patient days beyond the include charges f	g charity care tal operations igent care progrations in the second secon	ams (sum of ed Ins pat 2 2 , 181 , 575 , 381 , 194 th of stay	Flines sured ients .00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576 731,381 298,195	20 21 22 23 24
.00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off scharity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit	g charity care tal operations igent care progrations igent care progrations. Uninsure patient 1.00 y 3,812 (see 1,029 as 731 298 ys beyond a lengram? digent care progrations.	ams (sum of ed Ins pat 2 2 , 181 , 575 , 381 , 194 th of stay	Flines sured ients .00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20 21 22 23 24 25
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officiarity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care proglif line 24 is yes, enter the charges for patient days beyond the include charges f	g charity care tal operations igent care progrations igent care progrations. Uninsure patient 1.00 y 3,812 (see 1,029 as 731 298 ys beyond a lengram? digent care progrations)	ams (sum of ed Ins pat 2 2 , 181 , 575 , 381 , 194 th of stay	Flines sured ients .00	70tal (col. 1 + col. 2) 3.00 3,812,182 1,029,576 731,381 298,195	20 21 22 23 24 25 26
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officiality care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progif line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see	g charity care tal operations igent care progrations igent care progrations. Uninsure patient 1.00 y 3,812 (see 1,029 as 731 298 ys beyond a lengram? digent care progrations) e instructions)	ams (sum of ed Ins pat 2 2 , 181 , 575 , 381 , 194 th of stay	Flines sured ients .00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576 731,381 298,195	20. 21. 22. 23. 24. 25. 26. 27.
0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officharity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see instructions)	g charity care tal operations igent care progrations igent care progrations. Uninsure patient 1.00 y 3,812 (see 1,029 as 731 298 ys beyond a lengram? digent care progrations) e instructions) nstructions)	ams (sum of ed Ins pat 2 , 181 , 575 , 381 , 194 th of stay ram's length	Flines sured ients .00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20. 21. 22. 23. 24. 25. 26. 27. 28.
3. 00 2. 00 3. 00 4. 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off scharity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	g charity care tal operations igent care progrations igent care progrations. Uninsure patient 1.00 y 3,812 (see 1,029 as 731 298 ys beyond a lengram? digent care progrations) e instructions) nstructions)	ams (sum of ed Ins pat 2 , 181 , 575 , 381 , 194 th of stay ram's length	Flines sured ients .00	Total (col. 1 + col. 2) 3.00 3,812,182 1,029,576 731,381 298,195 1.00 N 0 512,131 11,189 17,214	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29. 29.

Heal th	Financial Systems	FRANCISCAN BEACO	ON HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					rom 01/01/2022	D 1 (T' D	
					o 12/31/2022	Date/Time Pre	pared:
	C+ C+ D	C-1:	0+1	T-+-1 (1 1	D1: 6:+:	5/30/2023 4:1	o piii
	Cost Center Description	Sal ari es	Other		Reclassificati		
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		1, 628, 707	1, 628, 707	0	1, 628, 707	1. 00
3.00	00300 OTHER CAP REL COSTS		0	(0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	621, 184	621, 184	0	621, 184	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	l ol	1, 827, 037	1, 827, 037	167, 618	1, 994, 655	5. 00
7.00	00700 OPERATION OF PLANT	l ol	673, 819	673, 819	0	673, 819	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	2, 529	1		2, 529	8. 00
9. 00	00900 HOUSEKEEPI NG		2, 288			2, 288	9. 00
10. 00	01000 DI ETARY		2, 036			2, 036	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	2,030	2,030	, 0	2,030	10.00
30. 00	03000 ADULTS & PEDIATRICS	3, 149, 143	12, 150	3, 161, 293	-3, 147, 841	13, 452	30. 00
30.00		3, 149, 143	12, 130	3, 101, 293	-3, 147, 041	13, 432	30.00
FO 00	ANCI LLARY SERVI CE COST CENTERS			1 .	V 0		
50.00	05000 OPERATI NG ROOM	0	0	i e	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	21, 716	21, 716	1, 045, 200	1, 066, 916	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	o	0	(0	0	56. 00
57.00	05700 CT SCAN	l ol	0	1	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	ol	0	1 (0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	أم	0	1	0	0	59. 00
60.00	06000 LABORATORY		1, 055, 861	1, 055, 861		1, 055, 861	60.00
60. 01	06001 BLOOD LABORATORY		1, 033, 001	1,033,001		1, 033, 001	60. 01
	1 1	١	0			1	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	9, 389	9, 389	0	9, 389	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	l ol	0	1	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	0	1 (0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	أم	0	1	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		187, 476	187, 476		187, 476	
74. 00	07400 RENAL DIALYSIS		107, 470	1		0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0				75.00
75. 00		0					
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	l U	0) 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0			0	
	09100 EMERGENCY	0	1, 908, 592	1, 908, 592	1, 935, 023	3, 843, 615	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		3, 149, 143	7, 952, 784	11, 101, 927	0	11, 101, 927	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
	19100 RESEARCH	o	0				191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	ا	0	1	ا م		192. 00
	19300 NONPALD WORKERS	ام	0		ol o		193. 00
200.00	1 1	3, 149, 143	7, 952, 784	11, 101, 927			
200.00	1 TOTAL (SOM OF LINES THE UNIONGH 199)	0, 147, 140	1, 752, 104	1 11, 101, 927	1	1 11, 101, 727	200.00

Peri od: From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/30/2023 4:15 pm

				5/30/2023 4: 1	.5 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	0	1, 628, 707		1.00
3.00	00300 OTHER CAP REL COSTS	0			3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-34, 254	1		5. 00
7.00	00700 OPERATION OF PLANT	0			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0			9. 00
10.00	01000 DI ETARY	0	2, 036		10. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	13, 452		30. 00
	ANCILLARY SERVICE COST CENTERS				1
50.00	05000 OPERATING ROOM	0	0		50.00
51. 00	05100 RECOVERY ROOM				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM				52.00
			1		
53.00	05300 ANESTHESI OLOGY	0			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	,		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	-		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56. 00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	ol ol		59. 00
60.00	06000 LABORATORY	0			60.00
60. 01	06001 BLOOD LABORATORY	0	,		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		-		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				62.00
					1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			64. 00
65. 00	06500 RESPI RATORY THERAPY	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	9, 389		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	ol ol		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		1		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		-		73. 00
		_	1,		
74. 00	07400 RENAL DIALYSIS	0			74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0			75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	0		90.00
91.00	09100 EMERGENCY	-1, 791, 868	2, 051, 747		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS		<u>'</u>		1
118.00		-1, 826, 122	9, 275, 805		118. 00
110.00	NONREI MBURSABLE COST CENTERS	1,020,122	7, 273, 003		1110.00
100.00			J 0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19100 RESEARCH	0	1		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	19300 NONPALD WORKERS	0	이		193. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-1, 826, 122	9, 275, 805	1	200. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0191	Period: Worksheet A-6 From 01/01/2022
		To 12/31/2022 Date/Time Prepared:

					5/30/2023 4:1	15 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4.00	5. 00		
	A - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	167, 618	0		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 045, 200	0		2. 00
3.00	EMERGENCY	91.00	1, 935, 023	0		3. 00
	TOTALS — — — — —		3, 147, 841	<u> </u>		
500.00	Grand Total: Increases		3, 147, 841	0		500.00

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0191 Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 4:15 pm

						5/30/2023 4: 1	15 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - SALARY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	3, 147, 841	C	(1.00
2.00		0.00	0	C	(2.00
3.00		0.00	0	C	(3.00
	TOTALS		3, 147, 841				
500.00	Grand Total: Decreases		3, 147, 841	C)	7	500.00

				10) 12/31/2022	5/30/2023 4:1	
				Acqui si ti ons		0,00,2020 11 1	<u> </u>
		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						
1.00	Land	1, 514, 351	0	0	0	0	1. 00
2.00	Land Improvements	42, 865	0	0	0	0	2. 00
3.00	Buildings and Fixtures	18, 535, 918	0	0	0	0	3. 00
4.00	Building Improvements	321, 825	0	0	0	0	4. 00
5.00	Fixed Equipment	3, 723, 493	38, 685	0	38, 685	0	5. 00
6.00	Movable Equipment	905, 250	0	0	0	0	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	25, 043, 702	38, 685	0	38, 685	0	8. 00
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	25, 043, 702	38, 685	0	38, 685	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				
1.00	Land	1, 514, 351	0				1.00
2.00	Land Improvements	42, 865	0				2.00
3.00	Buildings and Fixtures	18, 535, 918	0				3. 00
4.00	Building Improvements	321, 825	0				4. 00
5.00	Fi xed Equi pment	3, 762, 178	0				5. 00
6.00	Movable Equipment	905, 250	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	25, 082, 387	0				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	25, 082, 387	0				10. 00

Heal th	Financial Systems	FRANCISCAN BEACON HOSPITAL			In Lieu of Form CMS-2552-1			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022		pared:	
			Sl	JMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	1, 628, 707	0		0 0	0	1. 00	
3.00	Total (sum of lines 1-2)	1, 628, 707	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1) (sum					
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 628, 707				1. 00	
3. 00	Total (sum of lines 1-2)	0	1, 628, 707				3. 00	

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
				From 01/01/2022 To 12/31/2022	Part III Date/Time Prep	ared:
			'	12/31/2022	5/30/2023 4: 15	
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	·
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	3.00	
1. 00 CAP REL COSTS-BLDG & FLXT	18, 535, 918	0	18, 535, 918	1.000000	0	1. 00
3.00 Total (sum of lines 1-2)	18, 535, 918		18, 535, 918		0	3. 00
	ALLOCA ⁻	TION OF OTHER O			F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	/ 00	d Costs 7.00	through 7)	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	6.00	7.00	8. 00	9.00	10.00	
1.00 CAP REL COSTS-BLDG & FLXT	INILKS	0		1, 628, 707	0	1. 00
3.00 Total (sum of lines 1-2)	0	0		1, 628, 707	0	3. 00
or or in the result of the res	J	SL	JMMARY OF CAPI		J	0.00
Cost Center Description	Interest	Insurance (see		Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11 00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00 CAP REL COSTS-BLDG & FLXT	INILKS	0		0	1, 628, 707	1. 00
3.00 Total (sum of lines 1-2)	0	0			1, 628, 707	3. 00
5. 55 1.51a. (5am 51 11165 1 2)		١	1	1	1, 020, 707	0.00

					Fo 12/31/2022		pared:
				Expense Classification on		5/30/2023 4: 1	o piii
			Т	o/From Which the Amount is	to be Adjusted		
	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	
1. 00	Investment income - CAP REL	1.00		AP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	1	0 *	** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-32, 694 A	DMINISTRATIVE & GENERAL	5. 00	0	5. 00
6.00	Rental of provider space by		О		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		o		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-1, 791, 868			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	O			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests		0		0.00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		О		0.00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines		0		0.00	0	
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to				0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	OR	ESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0 P	HYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 *	** Cost Center Deleted ***	114. 00		25. 00
27.00	(chapter 21)		000	AD DEL COCTO DIDO « FLVT	1 00	0	24 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT			AP REL COSTS-BLDG & FIXT	1. 00	0	
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0 *	** Cost Center Deleted ***	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0 *	** Cost Center Deleted ***	19. 00	0	28. 00
29. 00 30. 00	,	A-8-3	00	CCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		OA	DULTS & PEDIATRICS	30. 00		30. 99
31. 00		A-8-3	os	PEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	OTHER INCOME	В	-1, 560 A	DMINISTRATIVE & GENERAL	5. 00	0	33. 00

Heal th	Financial Systems		FRANCISCAN BEA	CON HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0191	Peri od: From 01/01/2022	Worksheet A-8		
						Date/Time Pre 5/30/2023 4:1		
				Expense Classification o	n Worksheet A			
				To/From Which the Amount is	to be Adjusted			
					•			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
		1. 00	2. 00	3.00	4. 00	5. 00		
50.00	TOTAL (sum of lines 1 thru 49)		-1, 826, 122				50.00	
	(Transfer to Worksheet A,							
	column 6, line 200.)							

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

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

 B. Amount Received if cost cannot be determined.

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

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

						To 12/31/2022	2 Date/Time Pre 5/30/2023 4:1	epared: 15 nm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
				'			Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	91. 00	EMERGENCY	1, 791, 868	1, 791, 868	0	0	0	1. 00
2.00	0.00		0	C	0	0	0	2. 00
3.00	0.00		0	C	0	0	0	3. 00
4.00	0.00		0	C	0	0	0	4. 00
5.00	0.00		0	C	0	0	0	5. 00
6.00	0.00		0	C	0	0	0	6. 00
7. 00	0.00		0	C	0	0	0	7. 00
8.00	0.00		0	C	0	0	0	8. 00
9. 00	0.00		0	C	0	0	0	9. 00
10.00	0.00		0	C	0	0	0	10.00
200.00			1, 791, 868				0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit		Memberships &	Component	of Malpractice	
				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		EMERGENCY	0		_			
2.00	0. 00	1	0		_	0	-	
3. 00	0. 00		0	C	0	0	1	
4.00	0. 00		0	0	0	0	0	
5.00	0. 00		0		0	0	0	
6.00	0.00		0		0	0	0	0.00
7.00	0.00		0		0	0	0	
8.00	0.00		0		0	0	0	0.00
9.00	0.00		0		0	0	0	7.00
10.00	0. 00		0		0	0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200. 00
	WKSt. A Line #	I denti fi er	Component	Limit	Di sal I owance	Adjustment		
		rdentrirei	Share of col.	LIIIII	DI Sai i Owance			
			14					
	1, 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		EMERGENCY	0			1, 791, 868		1. 00
2. 00	0.00		0		_	0	1	2. 00
3. 00	0.00		0	0	0	0		3. 00
4. 00	0.00		0	l c	Ō	0		4. 00
5. 00	0.00		0	0	0	0		5. 00
6. 00	0.00		1 0		o o	Ö		6. 00
7. 00	0.00		0		Ō	Ō		7. 00
8. 00	0.00		0	i c	0	Ō		8. 00
9. 00	0. 00		0	C	Ō	Ö		9. 00
10.00	0.00		0	C	0	0		10.00
200.00			0	C	0	1, 791, 868		200.00
,		•	•		•			•

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0191

				T	12/31/2022		
			CAPI TAL			5/30/2023 4: 15	5 PM
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost		BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7)	1.00	4. 00	4A	5. 00	
	GENERAL SERVICE COST CENTERS	ŭ .	1.00	1. 00	171	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 628, 707	1, 628, 707				1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	621, 184	o	621, 184			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 960, 401	80, 182		2, 073, 646		5. 00
7. 00	00700 OPERATION OF PLANT	673, 819			858, 297		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 529			32, 507		8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 288 2, 036		0	9, 229 27, 227		9. 00 10. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2,030	25, 191	U	21, 221	7, 839	10.00
30. 00	03000 ADULTS & PEDIATRICS	13, 452	509, 395	257	523, 104	150, 612	30. 00
00.00	ANCILLARY SERVICE COST CENTERS	107 102	3077 070	207	020, 101	100/012	00.00
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 066, 916	356, 809		1, 629, 896		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00	06000 LABORATORY	1, 055, 861	25, 909	0	1, 081, 770		60. 00
60. 01	06001 BLOOD LABORATORY	0	20, 707	0	1,001,770	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	l o		ŭ	0	Ĭ	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
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	9, 389	18, 669	0	28, 058		69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	187, 476	13, 583	0	201, 059	_	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	o	0	0	o	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	o	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	0	0	_	90.00
91. 00	09100 EMERGENCY	2, 051, 747	377, 572	381, 693	2, 811, 012	809, 348	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	9, 275, 805	1, 628, 707	621, 184	9, 275, 805	2, 073, 646	110 00
110.00	NONREI MBURSABLE COST CENTERS	9, 275, 605	1,020,707	021, 104	7, 273, 603	2,073,040	110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	n	0	0	0	190. 00
	19100 RESEARCH	0	o	0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	ol	0	0		192. 00
193.00	19300 NONPALD WORKERS	0	o	0	0	0	193. 00
200.00					0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	9, 275, 805	1, 628, 707	621, 184	9, 275, 805	2, 073, 646	202. 00

			10) 12/31/2022	5/30/2023 4:1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Subtotal	
'	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	24.00	
GENERAL SERVICE COST CENTERS	_					
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 0PERATION OF PLANT	1, 105, 418					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	24, 294	66, 160				8. 00
9. 00 00900 HOUSEKEEPI NG	5, 625		,			9. 00
10. 00 01000 DI ETARY	20, 415	0	332	55, 813		10. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	412, 811	41, 253	6, 722	55, 813	1, 190, 315	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0			0	0	50. 00
51.00 05100 RECOVERY ROOM	0	_	-	0	0	51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	289, 156	0	4, 708	0	2, 393, 040	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (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	20, 997	0	342	0	1, 414, 572	60.00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
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	15, 129	0	246	0	51, 511	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	_	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 008		179	0	270, 135	73. 00
74. 00 07400 RENAL DI ALYSI S	0	_	0	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	_	0	0	0	75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	_	1		_1		
90. 00 09000 CLI NI C	0		0	0	0	90.00
91. 00 09100 EMERGENCY	305, 983	24, 907	4, 982	0	3, 956, 232	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS	4 405 440		47.544	FF 040	0.075.005	110 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 105, 418	66, 160	17, 511	55, 813	9, 275, 805	1118.00
NONREI MBURSABLE COST CENTERS				ما	0	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	U		190.00
191. 00 19100 RESEARCH	0	_	0	U		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	0	0	192.00
193. 00 19300 NONPALD WORKERS	0	1 0	0	o		193. 00
200.00 Cross Foot Adjustments		_				200.00
201.00 Negative Cost Centers	1 105 410	0	17 [1	0 EE 010	0 275 005	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 105, 418	66, 160	17, 511	55, 813	9, 275, 805	J2U2. UU

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0191 Period: Worksheet B

From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 4:15 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 1, 190, 315 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05100 RECOVERY ROOM 51.00 000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 393, 040 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 Ω 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 59 00 Ω 60.00 06000 LABORATORY 1, 414, 572 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000 62.00 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 51, 511 07000 ELECTROENCEPHALOGRAPHY 70 00 C 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 270, 135 73.00 07400 RENAL DIALYSIS 74.00 C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 3, 956, 232 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 9, 275, 805 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191. 00 19100 RESEARCH 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 0 0 193. 00 19300 NONPALD WORKERS 193. 00 0 200.00 200.00 Cross Foot Adjustments 0 201.00 Negative Cost Centers 0 C 201.00 202.00 TOTAL (sum lines 118 through 201) 9, 275, 805 202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 1 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0191

				To	12/31/2022	Date/Time Pre 5/30/2023 4:1	
			CAPI TAL			37 307 2023 4. 1	J piii
			RELATED COSTS				
	Cost Center Description	Di rectl y	BLDG & FLXT	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		Assigned New			BENEFI TS	& GENERAL	
		Capital Related Costs			DEPARTMENT		
		0	1. 00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	_	0	l .	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	80, 182		0	1	5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	184, 478		0	,, ,,	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	29, 978 6, 941		0	1	9. 00
10.00	01000 DI ETARY	0	25, 191		0	1	10.00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	0	509, 395	509, 395	0	5, 824	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	1	50.00
51.00	05100 RECOVERY ROOM	0	0	_	0	1	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	356, 809	-	0	1	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	j o	000,007	0	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	1	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	1	59. 00
60.00	06000 LABORATORY	0	25, 909	25, 909	0	12, 043	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U	0	0	0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	Ö	0	Ö	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	Ö	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	10.770	0	0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	18, 669 0	18, 669 0	0	312	69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	13, 583	13, 583	0	2, 238	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	-	0		75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0	0	0	0	90. 00
90.00	09100 EMERGENCY	0	377, 572		0	•	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		311,312	0	0	31, 270	92.00
	SPECIAL PURPOSE COST CENTERS			-			
118.00		0	1, 628, 707	1, 628, 707	0	80, 182	118. 00
	NONREI MBURSABLE COST CENTERS	1		I		T -	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES		0	0	0	•	191. 00 192. 00
	19300 NONPALD WORKERS		0	0	0		192. 00
200.00				Ö	O		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	1, 628, 707	1, 628, 707	0	80, 182	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0191

				To	12/31/2022	Date/Time Pre 5/30/2023 4:1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Subtotal	5 pili
	р	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	24. 00	
1 00	GENERAL SERVICE COST CENTERS	I		I			4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	104 022					5. 00 7. 00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	194, 033 4, 264	34, 604				8.00
9. 00	00900 HOUSEKEEPING	987	34,604				9.00
10. 00	01000 DI ETARY	3, 583	0	0,00.	29, 229		10.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	3, 303	0	152	27, 227		10.00
30. 00	03000 ADULTS & PEDIATRICS	72, 461	21, 578	3, 083	29, 229	641, 570	30. 00
	ANCILLARY SERVICE COST CENTERS	1=7.101	=1, 51.5	2, 222		211,1212	
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	50, 755	0	2, 159	0	427, 869	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	O	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	o	0	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (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	3, 686	0	157	0	41, 795	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	-	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	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	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 656	0		0	21, 750	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	· ·	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1 022	0	0	0	17.025	72.00
74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 932	0	82 0	ĭ	17, 835	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	<u> </u>		17.00
90.00	09000 CLI NI C	0	0	0	O	0	90.00
91. 00	09100 EMERGENCY	53, 709	13, 026	_	Ö	477, 888	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	00,707	10,020	2,200	Ĭ	177,000	92.00
,2.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		194, 033	34, 604	8, 031	29, 229	1, 628, 707	118. 00
	NONREI MBURSABLE COST CENTERS			, , , , ,	, ,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	o	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o	0	192. 00
193.00	19300 NONPALD WORKERS	0	0	0	o	0	193. 00
200.00	Cross Foot Adjustments					0	200. 00
201.00		0	0	0	o		201. 00
202.00	TOTAL (sum lines 118 through 201)	194, 033	34, 604	8, 031	29, 229	1, 628, 707	202. 00

Heal th Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0191 Period: Worksheet B

From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/30/2023 4:15 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 641, 570 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05100 RECOVERY ROOM 51.00 000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 427, 869 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 Ω 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 Ω 60.00 06000 LABORATORY 41, 795 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000 0 62.00 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 21, 750 07000 ELECTROENCEPHALOGRAPHY 70 00 C 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 17, 835 73.00 07400 RENAL DIALYSIS 74.00 C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 477, 888 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 628, 707 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 0 0 193. 00 19300 NONPALD WORKERS 193. 00 0 200.00 200.00 Cross Foot Adjustments 0 201.00 Negative Cost Centers 0 C 201.00 202.00 TOTAL (sum lines 118 through 201) 1, 628, 707 202.00

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT	у риг
			1.00	4.00	5A	5. 00	7. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT	27, 219					1. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	3, 149, 143	1			4. 00
5.00		ADMINISTRATIVE & GENERAL	1, 340	167, 618			1	5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	3, 083 501	0			•	7. 00 8. 00
9. 00		HOUSEKEEPING	116	0	0			1
10. 00		DI ETARY	421	0	Ö			10.00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDI ATRI CS	8, 513	1, 302	0	523, 104	8, 513	30.00
		LARY SERVICE COST CENTERS			1 -		_	
50.00		OPERATI NG ROOM	0	0	1		•	1
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	0	1	_		
53. 00		ANESTHESI OLOGY		0	0			1
54. 00		RADI OLOGY-DI AGNOSTI C	5, 963	1, 045, 200		_		1
55.00		RADI OLOGY-THERAPEUTI C	o	0	0	0	0	55. 00
56. 00	1	RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00		CT SCAN	0	0	0	0	0	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	_	0	
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	433	0	0	_	0	
60. 00	1	BLOOD LABORATORY	433	0	0		433	
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY		O	0	_		61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	Ō	0	0	1
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	o	0	0	0	0	63.00
64. 00	1	I NTRAVENOUS THERAPY	0	0	0	0	0	
65.00		RESPI RATORY THERAPY	0	0	0	0	0	
66. 00		PHYSI CAL THERAPY	0	0	0	0	0	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	_	_	
69. 00	1	ELECTROCARDI OLOGY	312	0	ő	_		
70. 00		ELECTROENCEPHALOGRAPHY	0	0	ő		1	1
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	0	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	_	0	
73. 00		DRUGS CHARGED TO PATIENTS	227	0	0		l e	1
74. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0	0	_	1	1
75. 00 77. 00		ALLOGENEIC STEM CELL ACQUISITION		0		_		
77.00		TIENT SERVICE COST CENTERS	١				J	77.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91. 00		EMERGENCY	6, 310	1, 935, 023	0	2, 811, 012	6, 310	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
110 00		AL PURPOSE COST CENTERS	27 210	2 140 142	2 072 (4(7 202 150	22.704	110 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	27, 219	3, 149, 143	-2, 073, 646	7, 202, 159	22, 196	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	C	0	0	0	190. 00
	1	RESEARCH	o o	0	1			191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	O	0	0	0	0	192. 00
		NONPALD WORKERS	0	0	0	0	· O	193. 00
200.00	1	Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	1 (20 707	/01 104		2 072 /4/	1 105 110	201. 00
202. 00	'	Cost to be allocated (per Wkst. B, Part I)	1, 628, 707	621, 184		2, 073, 646	1, 105, 418	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	59. 837136	0. 197255		0. 287920	48. 491753	203. 00
204.00	1	Cost to be allocated (per Wkst. B,	11.007.00	0		80, 182	1	
		Part II)						
205.00)	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 011133	8. 511713	205. 00
204 00		NAME adjustment amount to be allegated						204 00
206. 00	'	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00		NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0191

				To) 12/31/2022 Date/Time Pi 5/30/2023 4:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	07 007 2020 1.	TO PIII
		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)		
		(GROSS				
		CHARGES) 8.00	9. 00	10.00		
GENE	RAL SERVICE COST CENTERS	0.00	7.00	10.00		
	O CAP REL COSTS-BLDG & FIXT					1. 00
4.00 0040	O EMPLOYEE BENEFITS DEPARTMENT					4. 00
1	O ADMINISTRATIVE & GENERAL					5. 00
	O OPERATION OF PLANT	E 0/0 00E				7.00
	O LAUNDRY & LINEN SERVICE O HOUSEKEEPING	5, 069, 885	22, 179			8. 00 9. 00
	O DI ETARY	0	421	1		10.00
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS	3, 161, 293	8, 513	105		30. 00
	LLARY SERVICE COST CENTERS OOOPERATING ROOM	1 0		l ol		F0.00
	O RECOVERY ROOM	0				50. 00 51. 00
	O DELIVERY ROOM & LABOR ROOM	0	ĺ	Ö		52.00
	O ANESTHESI OLOGY	0	O	0		53.00
	O RADI OLOGY-DI AGNOSTI C	0	5, 963	0		54.00
	O RADI OLOGY-THERAPEUTI C	0	0	1		55. 00
	O RADI OI SOTOPE	0	0	0		56. 00
	O CT SCAN O MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		57. 00
	O CARDIAC CATHETERIZATION	0				58. 00 59. 00
	O LABORATORY	0	433	_		60.00
	1 BLOOD LABORATORY	0	0	1		60. 01
	O PBP CLINICAL LAB SERVICES-PRGM ONLY		-			61. 00
62. 00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62. 00
	O BLOOD STORING, PROCESSING & TRANS.	0	0	0		63. 00
	O I NTRAVENOUS THERAPY	0	0	0		64.00
1	O RESPI RATORY THERAPY O PHYSI CAL THERAPY	0		0		65. 00 66. 00
	O OCCUPATIONAL THERAPY					67.00
	O SPEECH PATHOLOGY	0	Ö	_		68. 00
69. 00 0690	O ELECTROCARDI OLOGY	0	312	0		69. 00
1	0 ELECTROENCEPHALOGRAPHY	0	0			70. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	_		71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72. 00
	O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS	0	227	1		73. 00 74. 00
	O ASC (NON-DISTINCT PART)	0	ĺ			75. 00
	O ALLOGENEIC STEM CELL ACQUISITION	0	O	1		77. 00
	ATIENT SERVICE COST CENTERS	,				
	O CLI NI C	0	0			90.00
	O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART)	1, 908, 592	6, 310	0		91. 00 92. 00
	I AL PURPOSE COST CENTERS		<u> </u>			72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 069, 885	22, 179	105		118. 00
	EIMBURSABLE COST CENTERS	,				
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. 00
191. 00 1910		0	0	_		191. 00
	O PHYSICIANS' PRIVATE OFFICES O NONPAID WORKERS	0	0	0		192. 00 193. 00
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B,	66, 160	17, 511	55, 813		202. 00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 013050	l e	1		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	34, 604	8, 031	29, 229		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 006825	0. 362099	278. 371429		205. 00
200.00	II)	3. 000020	3. 552577			
206. 00	NAHE adjustment amount to be allocated					206. 00
207 00	(per Wkst. B-2)					207.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00
ı	1	I .	1	1		1

Health Financial Systems	FRANCISCAN BEA	ACON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 4:19	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	

Title XVIII Hospital PPS Cost Center Description Total Cost Cfrom Wkst. B, Part I, col. 20 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00
INPATIENT ROUTINE SERVICE COST CENTERS 1, 100 2, 00 3, 00 4, 00 5, 00
Total Cost (From Wist. B, Part I, col. 26)
NPATI ENT ROUTINE SERVICE COST CENTERS 1, 190, 315 1, 190, 315 30, 00 30, 00 4, 00 5, 00 30, 00 30, 00 4, 00 5, 00 30, 00
NPATI ENT ROUTI NE SERVI CE COST CENTERS 1, 190, 315 1, 190, 315 0 1, 190, 315 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
INPATIENT ROUTINE SERVICE COST CENTERS 1,190,315 1,190,315 0 1,190,315 30.00
INPATIENT ROUTINE SERVICE COST CENTERS 1,190,315 1,190,315 0 1,190,315 30.00 3000 ADULTS & PEDI ATRI CS 1,190,315 1,190,315 0 1,190,315 30.00 3000 ADULTS & PEDI ATRI CS
30. 00 03000 ADULTS & PEDIATRICS 1, 190, 315 1, 190, 315 0 1, 190, 315 30. 00 ANCILLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
ANCI LLARY SERVI CE COST CENTERS
50.00
51. 00 05100 RECOVERY ROOM 0 0 51. 00 51. 00 0 0 51. 00 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 52. 00 0 0 0 52. 00 0 0 0 52. 00 0 0 0 52. 00 0 0 0 52. 00 0 0 0 0 0 53. 00 53. 00 0 0 0 0 53. 00 55. 00 0 0 0 54. 00 0 0 0 55. 00 55. 00 0 0 0 0 0 0 55. 00 55. 00 0
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 393, 040 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 0 0 55. 00 0 0 0 0 0 0 55. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 55. 00 0
53. 00 05300 ANESTHESI OLOGY 0 0 53. 00 53. 00 53. 00 0 0 53. 00 53. 00 53. 00 0 0 54. 00 54. 00 54. 00 0 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 2, 393, 040 0 0 0 55. 00 0 0 0 0 55. 00 0 0 0 0 0 0 55. 00 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 393, 040 2, 393, 040 0 2, 393, 040 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55. 00 56. 00 05700 CT SCAN 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 59. 00 60. 01 06000 LABORATORY 1, 414, 572 1, 414, 572 0 1, 414, 572 0 1, 414, 572 0
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 00 56. 00 05600 RADI OI SOTOPE 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 1, 414, 572 0 1, 414, 572 60. 00 0 60. 01 60. 01 0 0 0 0 0 0 0 0 0 0 0 1, 414, 572 0 1, 414, 572 0 1, 414, 572 0 </td
56. 00 05600 RADI OI SOTOPE 0 0 56. 00 56. 00 57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 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, 414, 572 0 1, 414, 572 0 1, 414, 572 0 1, 414, 572 0 0 60. 00 60. 01 06100 DBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 0 0 0 60. 00 0 </td
57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00 60. 01 06000 LABORATORY 1, 414, 572 1, 414, 572 0 1, 414, 572 60. 00 60. 01 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 63. 00 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 <t< td=""></t<>
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58. 00 58. 00 59. 00 0 0 0 58. 00 59. 00 0 0 0 59. 00 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 59. 00 0 0 0 0 59. 00 0
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 00 60. 00 06000 LABORATORY 1, 414, 572 1, 414, 572 0 1, 414, 572 60. 00 60. 01 06001 BLOOD LABORATORY 0
60. 00 06000 LABORATORY 1,414,572 1,414,572 0 1,414,572 60. 00 0 0 0 0 0 0 0 0
60. 01
61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62. 00 63. 00 63. 00 64. 00 64. 00 64. 00 65. 00 65. 00 66. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63. 00 64. 00 64. 00 65. 00 65. 00 66. 00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67. 00 07. 00 08. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 65. 00 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 07.
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 66. 00 67. 00 067. 00 0 0 0 0 0 0 0 0 0
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 67. 00
40 00 04000 CDEECH DATHOLOGY
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00
69. 00 06900 ELECTROCARDI OLOGY 51, 511 51, 511 0 51, 511 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 270, 135 270, 135 0 270, 135 73. 00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 00
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 77. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 0 0 0 0 90. 00
91. 00 09100 EMERGENCY 3, 956, 232 3, 956, 232 0 3, 956, 232 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 427,978 427,978 427,978 427,978 92.00
200.00 Subtotal (see instructions) 9,703,783 0 9,703,783 0 9,703,783
201.00 Less Observation Beds 427, 978 427, 978 427, 978 427, 978
202. 00 Total (see instructions) 9, 275, 805 0 9, 275, 805 0 9, 275, 805

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0191	Peri od: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

					To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared: 5 pm
		_		XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						1
	000 ADULTS & PEDIATRICS	252, 159		252, 15	9		30.00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0	(0. 000000	0. 000000	
	100 RECOVERY ROOM	0	0	(0. 000000	0. 000000	
	200 DELIVERY ROOM & LABOR ROOM	0	0	(0. 000000	0. 000000	
	300 ANESTHESI OLOGY	0	0	(0. 000000	0. 000000	
	400 RADI OLOGY-DI AGNOSTI C	116, 727	14, 411, 635	14, 528, 36		0. 000000	1
	500 RADI OLOGY-THERAPEUTI C	0	0		0.000000	0. 000000	
56. 00 05	600 RADI OI SOTOPE	0	0	(0.000000	0.000000	56. 00
57. 00 05	700 CT SCAN	0	0	(0.000000	0.000000	57. 00
58. 00 05	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0.000000	0.000000	58. 00
59. 00 05	900 CARDI AC CATHETERI ZATI ON	0	0	(0.000000	0.000000	59. 00
60.00 06	000 LABORATORY	277, 895	5, 692, 650	5, 970, 54	0. 236925	0.000000	60.00
60. 01 06	001 BLOOD LABORATORY	O	0		0. 000000	0.000000	60. 01
61.00 06	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000	0.000000	61. 00
62. 00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O	0		0. 000000	0.000000	62.00
	300 BLOOD STORING, PROCESSING & TRANS.	O	0		0. 000000	0. 000000	63. 00
	400 I NTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	64. 00
65. 00 06	500 RESPI RATORY THERAPY	ol	0		0. 000000	0. 000000	65. 00
	600 PHYSI CAL THERAPY	O	0		0. 000000	0. 000000	
	700 OCCUPATI ONAL THERAPY	O	0		0. 000000	0. 000000	
	800 SPEECH PATHOLOGY	0	0		0. 000000	0. 000000	1
	900 ELECTROCARDI OLOGY	134, 875	971, 608	1, 106, 48		0. 000000	1
	000 ELECTROENCEPHALOGRAPHY	0	0	1, 100, 10	0. 000000	0. 000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	
	300 DRUGS CHARGED TO PATIENTS	89, 544	1, 153, 045	1, 242, 58		0. 000000	1
	400 RENAL DIALYSIS	0,,011	1, 100, 010		0. 000000	0. 000000	
	500 ASC (NON-DISTINCT PART)		0		0. 000000	0. 000000	
	700 ALLOGENEIC STEM CELL ACQUISITION		0		0.000000	0. 000000	1
	TPATIENT SERVICE COST CENTERS	١		<u> </u>	0.000000	0.000000	77.00
	000 CLINIC	n	0		0.000000	0. 000000	90.00
	100 EMERGENCY	116, 211	10, 975, 965			0. 000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	110, 211	153, 013			0. 000000	1
200.00	Subtotal (see instructions)	987, 411	33, 357, 916			0.00000	200.00
200.00	Less Observation Beds	707, 411	33, 337, 910	34, 343, 32	<u>'</u>		200.00
201.00	Total (see instructions)	987, 411	33, 357, 916	34, 345, 32 ⁻	7		201.00
202.00	Total (See Histiactions)	707,411	33, 337, 910	34, 343, 32	' I		1202.00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-019	From 01/01/2022	Worksheet C Part I Date/Time Prepared: 5/30/2023 4:15 pm

				5/30/2023 4:15 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50. 00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 164715			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 236925			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
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. 046554			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 217397			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.00
OUTPATIENT SERVICE COST CENTERS	0.000000			77.00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 356669			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2. 797004			92. 00
200.00 Subtotal (see instructions)	2. 7 7 7 0 0 4			200. 00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
202. 00 Total (See Histructions)	1			J202. 00

Health Financial Systems	FRANCISCAN BEACON	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prep 5/30/2023 4:15	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		

					To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
	<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.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 190, 315		1, 190, 31	5 0	1, 190, 315	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0			0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0			0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0			0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 393, 040		2, 393, 04	0	2, 393, 040	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0			0 0	0	56. 00
57. 00	05700 CT SCAN	0			0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60.00	06000 LABORATORY	1, 414, 572		1, 414, 57	2 0	1, 414, 572	60. 00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	l .	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	51, 511		51, 51	.	51, 511	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	270, 135		270, 13		270, 135	•
74.00	07400 RENAL DIALYSIS	0			0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	0	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	0		ı			00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	3, 956, 232		3, 956, 23	0 0	0	90.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 956, 232				3, 956, 232 427, 978	
200.00		9, 703, 783	0	427, 97 9, 703, 78		9, 703, 783	
200.00		9, 703, 783 427, 978	0	9, 703, 78 427, 97		9, 703, 783 427, 978	
201.00		9, 275, 805	0				
202.00	Total (See Histiactions)	7, 213, 603	U	7, 213, 00	J ₁ V ₁	7, 210, 000	1202.00

Health Financial Systems FRANCISCAN BEACON HOSPITAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCM	CN: 15-0191	From 01/01/2022	Worksheet C Part I Date/Time Prepared:

					To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared: 5 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	252, 159		252, 15	9		30. 00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0		0.000000	0. 000000	
	100 RECOVERY ROOM	0	0		0.000000	0. 000000	
	200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000	0. 000000	
	BOO ANESTHESI OLOGY	0	0		0.000000	0. 000000	
54.00 054	100 RADI OLOGY-DI AGNOSTI C	116, 727	14, 411, 635	14, 528, 36	0. 164715	0.000000	54.00
55. 00 055	600 RADI OLOGY-THERAPEUTI C	0	0		0.000000	0.000000	55. 00
56.00 056	600 RADI OI SOTOPE	0	0		0.000000	0.000000	56. 00
57. 00 057	700 CT SCAN	0	0		0.000000	0.000000	57. 00
58. 00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	0	0		0.000000	0.000000	58. 00
59. 00 059	POO CARDI AC CATHETERI ZATI ON	0	0		0.000000	0.000000	59. 00
60.00 060	000 LABORATORY	277, 895	5, 692, 650	5, 970, 54	0. 236925	0.000000	60.00
60. 01 060	001 BLOOD LABORATORY	O	0		0.000000	0.000000	60. 01
61. 00 061	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	O	0		0.000000	0.000000	61.00
62. 00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0		0. 000000	0.000000	62.00
	BOO BLOOD STORING, PROCESSING & TRANS.	o	0		0. 000000	0. 000000	63. 00
	100 INTRAVENOUS THERAPY	O	0		0. 000000	0. 000000	64. 00
65. 00 065	500 RESPIRATORY THERAPY		0		0. 000000	0. 000000	65. 00
	500 PHYSI CAL THERAPY	o	0		0. 000000	0. 000000	
	700 OCCUPATIONAL THERAPY	o	0		0. 000000	0. 000000	
	BOO SPEECH PATHOLOGY	0	0		0. 000000	0. 000000	
	900 ELECTROCARDI OLOGY	134, 875	971, 608	1, 106, 48		0. 000000	
	000 ELECTROENCEPHALOGRAPHY	0	0	1,,	0. 000000	0. 000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	
	BOO DRUGS CHARGED TO PATIENTS	89, 544	1, 153, 045	1, 242, 58		0. 000000	1
	400 RENAL DIALYSIS	0,,011	1, 100, 010		0. 000000	0. 000000	
	500 ASC (NON-DISTINCT PART)		0		0. 000000	0. 000000	
	700 ALLOGENEIC STEM CELL ACQUISITION		0		0. 000000	0. 000000	1
	TPATIENT SERVICE COST CENTERS	١		<u> </u>	0.000000	0.000000	77.00
	000 CLINIC		0		0.000000	0. 000000	90.00
	100 EMERGENCY	116, 211	10, 975, 965			0. 000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	110, 211	153, 013			0. 000000	1
200. 00	Subtotal (see instructions)	987, 411	33, 357, 916			0.00000	200.00
200.00	Less Observation Beds	707,411	33, 337, 910	34, 343, 32	<u>'</u>		201.00
201.00	Total (see instructions)	987, 411	33, 357, 916	34, 345, 32	7		201.00
202.00	Tiotal (See Histiactions)	707, 411	33, 337, 910] 34, 343, 32	'		1202.00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lieu of Form CMS	3-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-019	91	repared:

				10 12/31/2022	5/30/2023 4: 1	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30. 00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50. 00
	05100 RECOVERY ROOM	0. 000000				51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
	05600 RADI OI SOTOPE	0. 000000				56. 00
57.00	05700 CT SCAN	0. 000000				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (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
	06001 BLOOD LABORATORY	0. 000000				60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
64.00	06400 INTRAVENOUS THERAPY	0. 000000				64.00
	06500 RESPI RATORY THERAPY	0. 000000				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66. 00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
	06800 SPEECH PATHOLOGY	0. 000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
	07400 RENAL DIALYSIS	0. 000000				74. 00
	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0. 000000				90.00
	09100 EMERGENCY	0. 000000				91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92. 00
200.00	l '					200. 00
201.00	l					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		pared.
				10 12/01/2022	5/30/2023 4:1	5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	641, 570	C	641, 570	178	3, 604. 33	30.00
200.00 Total (lines 30 through 199)	641, 570		641, 570	178		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 ADULTS & PEDIATRICS	51		1			30. 00
200.00 Total (lines 30 through 199)	51	183, 821				200. 00

Health Financial Sy	rstems	FRANCISCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF IN	NPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	
			Ti tl e	e XVIII	Hospi tal	5/30/2023 4: 1 PPS	5 pm
Cost Ce	enter Description		Total Charges (from Wkst. C, Part I, col. 8)	to Charges	t Inpatient Program	Capital Costs (column 3 x column 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	

		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 + col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	427, 869	14, 528, 362	0. 029451	75, 454	2, 222	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.000000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	O	0.000000	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0.000000	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 000000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 000000	0	0	59.00
60. 00 06000 LABORATORY	41, 795	5, 970, 545	0. 007000	143, 537	1, 005	60.00
60. 01 06001 BL00D LABORATORY	0	0	0. 000000	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000	0	o	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	o	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 000000	0	O	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	0. 000000	0	o	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0. 000000	0	o	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 000000	0	o	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 000000	0	o	68. 00
69. 00 06900 ELECTROCARDI OLOGY	21, 750	1, 106, 483	0. 019657	64, 594	1, 270	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 000000	0	o	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 000000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 835	1, 242, 589	0. 014353	44, 537	639	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0.000000	0	o	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 000000	0	o	75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 000000	0	o	77. 00
OUTPATIENT SERVICE COST CENTERS	•		,			İ
90. 00 09000 CLI NI C	0	0	0.000000	0	0	90.00
91. 00 09100 EMERGENCY	477, 888	11, 092, 176		70, 637	3, 043	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	230, 677			0	0	1
200.00 Total (lines 50 through 199)	1, 217, 814			398, 759	8, 179	200. 00
			'			

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	rs Provider Co		Period: From 01/01/2022 To 12/31/2022		pared: 5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	17 17		l	30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems		FRANCI SC	AN BEACON	HOSPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE OTH	ER PASS	Provi der	CCN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared:

				To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
		Title	XVIII	Hospi tal	PPS	5 piii
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
oost conton boscii pti cii	Anesthetist	Program	Program	Post-Stepdown	7 od modi tii	
	Cost	Post-Stepdown		Adjustments		
		Adjustments		.,		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	56. 00
57.00 05700 CT SCAN	0	0		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00 06000 LABORATORY	0	0		0	0	60.00
60. 01 06001 BL00D LABORATORY	0	0		0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
74. 00 07400 RENAL DI ALYSI S	0	0		0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLI NI C	0	0		0	-	
91. 00 09100 EMERGENCY	0	0		0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		U	0	1 /2.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA THROUGH COSTS	RY SERVICE OTHER PASS	S Provider C	CN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/30/2023 4:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total Outpatient		Ratio of Cost	

					0 12/31/2022	5/30/2023 4:1	
			Title	· XVIII	Hospi tal	PPS	<u>o p</u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
		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)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	(0	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(14, 528, 362	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0	(0	0.000000	56. 00
57.00	05700 CT SCAN	0	0	(0	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		o	0.000000	59. 00
60.00	06000 LABORATORY	0	0		5, 970, 545	0.000000	60. 00
60. 01	06001 BLOOD LABORATORY	0	0		o	0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		o	0.000000	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		o	0.000000	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		o	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		o o	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		o	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		o	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		o o	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		1, 106, 483	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		o	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		1, 242, 589	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0. 000000	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0. 000000	75. 00
77. 00	07700 ALLOĞENEIC STEM CELL ACQUISITION	0	0		0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS	,					
90.00	09000 CLI NI C	0	0		0	0.000000	90.00
91. 00	09100 EMERGENCY	0	0		11, 092, 176		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		153, 013		
200.00		0	0		34, 093, 168		200. 00
	1 (1		'		1	

Health Financial Systems	FRANCISCAN BEACON	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0191	From 01/01/2022	Worksheet D Part IV Date/Time Prepared: 5/30/2023 4:15 pm

Tilloodi costs			To	12/31/2022	Date/Time Pre 5/30/2023 4:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	75, 454	0	3, 984, 037	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0	0	0	0	56.00
57. 00 05700 CT SCAN	0. 000000	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59.00
60. 00 06000 LABORATORY	0. 000000	143, 537	0	363, 395	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	64, 594	0	439, 372	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0.,0,.	0	0.07,072	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	o o	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	44, 537	Ŏ	365, 301	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	44, 557 O	0	303, 301 N	Ö	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0	<u> </u>	0	0	17.00
90. 00 09000 CLI NI C	0. 000000	0	O	n	0	90.00
91. 00 09100 EMERGENCY	0. 000000	70, 637		2, 385, 131	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	, o, os i	0	35, 689	0	92.00
200.00 Total (lines 50 through 199)	0.000000	398, 759		7, 572, 925	_	200.00
200.00 10tal (111103 00 till ough 177)		370, 737	١	1, 512, 725	0	1200.00

51. 00 05100 RECOVERY ROOM 0.000000 0	ared: pm
Cost Center Description	
Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Services (subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)	
Worksheet C, Part I, col. 9 inst.) Services Subject To Ded. & Coins. (see inst.)	
Part I, col. 9 Subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)	
Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)	
ANCI LLARY SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00	
ANCI LLARY SERVI CE COST CENTERS	
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0.000000 0 <t< td=""><td></td></t<>	
51. 00 05100 RECOVERY ROOM 0.000000 0	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 656, 231 0 <td< td=""><td>50.00</td></td<>	50.00
53. 00 05300 ANESTHESI OLOGY 0.000000 0 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.164715 3,984,037 0 0 656,231 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 57. 00 05700 CT SCAN 0.000000 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 60. 00 06000 LABORATORY 0.236925 363,395 0 0 86,097	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 164715 3, 984, 037 0 0 656, 231 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 57. 00 05700 CT SCAN 0. 000000 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 000000 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0 0 0 0 60. 00 06000 LABORATORY 0. 236925 363, 395 0 0 86, 097	52. 00 53. 00
55. 00 05500 RADI 0 LOGY-THERAPEUTI C 0.000000 0	
56. 00 05600 RADI OI SOTOPE 0.000000 0 <td< td=""><td>54.00</td></td<>	54.00
57. 00 05700 CT SCAN 0.000000 0	55. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 60. 00 06000 LABORATORY 0.236925 363, 395 0 0 86, 097	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0 0 0 0 0 0 0 86, 097 0 86, 097 0 86, 097 0 0 86, 097 0	57. 00
60. 00 06000 LABORATORY	58. 00
	59. 00
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	70. 00
	71. 00
	72. 00
	73. 00
	74. 00
	75. 00
	77. 00
OUTPATIENT SERVICE COST CENTERS	00 00
	90.00
	91. 00
	92.00
200.00 Subtotal (see instructions)	
	01. 00
Only Charges	02. 00

Health Financial Systems		FRANCISCAN BEACON	I HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES A	AND VACCINE COST	Provider CCN: 15-0191		Worksheet D Part V Date/Time Prepared:

				To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
-		Title	: XVIII	Hospi tal	PPS	то рііі
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-	1			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1			64. 00
65. 00 06500 RESPIRATORY THERAPY	0	1	1			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	Ö	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67. 00
68. 00 06800 SPEECH PATHOLOGY	Ö	1	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1	1			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	1			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		1	1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		233	1			73. 00
74. 00 07400 RENAL DIALYSIS			1			74.00
75. 00 07500 ASC (NON-DISTINCT PART)						75.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION						77. 00
OUTPATIENT SERVICE COST CENTERS						177.00
90. 00 09000 CLINI C	0	0				90.00
91. 00 09100 EMERGENCY		1	1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			•			92.00
, ,		1	1			200.00
						•
201.00 Less PBP Clinic Lab. Services-Program Only Charges						201. 00
202.00 Net Charges (line 200 - line 201)	0	233				202. 00
202.00	1	1 233	I			1202.00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0191	Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

PART 1.2 LL REPOLING COMPOSETS 1.00 PART 1.2 LL REPOLING COMPOSETS 1.00 Impatient days (including private roun days and saing-bed days, excluding newborn) 178 1.00 Impatient days (including private roun days, excluding saing-bed and newborn days) 178 2.00 Inpatient days (including private roun days, excluding saing-bed and newborn days) 178 2.00 Inpatient days (including private roun days, excluding saing-bed and newborn days) 178 2.00 Inpatient days (including saing-bed and observation bed days) 179 179 un tavo only private room days, excluding saing-bed and representation bed days) 179 un tavo only private room days 178 2.00 Inpatient days (including saing-bed and observation bed days) 179 un tavo only private room days 179			Title XVIII	Hospi tal	PPS	э ріп
INSMITTER IDMS INSMITTER IDMS Inpatient days (including private room days, box duding pering-bed days, excluding newborn) 1.00 Inpatient days (including private room days, box duding pering-bed and mexican days) 1.00 Inpatient days (including private room days, box duding pering-bed and beaversation bed days). If you have end y private room days, do not complete this line. 1.00 1.		Cost Center Description				
Impartient Day's 1.00 Impartient days (including private room days and swing-bed days, excluding needorm) 1.78 1.00 Impartient days (including private room days, excluding swing-bed and hemborn days) 1.78 2.00 1.00		DADT I ALL DOOM DED COMPONENTO			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 178 2.00						
Impatient days (including private room days, excluding swing-bed and neshborn days) 178 2.00	1 00		s excluding newborn)		178	1 00
Private room days (excluding saing-bed and observation bed days) 1						
5.00 Total swing-hed SKF type inpartient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including period (see instructions) 10. Os bing-bed SMF type inpartient days applicable to title SVI or XIX only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 11. Os bing-bed KF type inpartient days applicable to titles V or XIX only (including private room days) 12. Os bing-bed KF type inpartient days applicable to titles V or XIX only (including private room days) 13. Os bing-bed KF type inpartient days applicable to services after December 31 of the cost reporting period (including private room days) 14. On Medical Inviersy days (title V or XIX only) 15. On Total nursery days (title V or XIX only) 16. On Medical room to the services applicable to services through December 31 of the cost reporting period (including period in a reporting period (including private room days) 17. On Medical room to the service of the period reporting period				vate room days,		
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Total swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00	5.00		om days) through December	31 of the cost	0	5. 00
reporting period (if Calendar year, either 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period to swing-bed NF type inpatient days (including private room days) after December 31 of the cost total inpatient days including private room days) after December 31 of the cost on the line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 10.00 through December 31 of the cost reporting period (including private room days) 3 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room day	6 00		om days) after December 3	R1 of the cost	0	6 00
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reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through becember 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only relating private room days) after on through becember 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Wedically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Necessary private room days applicable to the Program (excluding swing-bed days) 17.00 New York (title V or XIX only) 18.00 Necessary days (ti						
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through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to the Program (excluding swing-bed days) 1.01 On Total pursery days (title V or XIX only) 1.02 On Total pursery days (title V or XIX only) 1.03 On Nursery days (title V or XIX only) 1.04 Nursery days (title V or XIX only) 1.05 Will No BED ADJUSTNINI 1.06 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 1.00 Redicare rate for swing-bed SNF services applicable to services after December 31 of the cost 1.00 Redicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Redicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Redicard rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Redicard rate for swing-bed NF services applicable to services after December 31 of the cost 1.10 Redicard rate for swing-bed NF services applicable to services after December 31 of the cost 1.10 Redicard rate for swing-bed NF services applicable to services after December 31 of the cost 1.10 Redicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 2 2.00 Certain period (line 6 2 2.00 Certai	10.00		nly (including private ro	oom days)	0	10.00
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14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 00 0 15. 00 16. 00 Nursery days (title V or XIX only) 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00 0 15. 00	13. 00		only (including private	e room days)	0	13. 00
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32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00			- line 28)		-	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 34.00 34.00 35.00 36.00 37.00 37.00 37.00 38.00 37.00 38.00 38.00 38.00 40.00		,	,			
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35.00 36.00 37.00 37.00 37.00 37.00 37.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.0	34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	35.00	Average per diem private room cost differential (line 34 x line	ne 31)		0.00	35.00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 6, 687.16 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 6,687.16 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	,	and private room cost dif	ferential (line	1, 190, 315	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 38.00 39.00 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 6,687.16 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 6,687.16 38.00 341,045 39.00 40.00			JSTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 341,045 39.00 40.00	38. 00				6, 687. 16	38. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 341,045 41.00		1 3 1			-	
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		341, 045	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCISCAN BEACO	Provider C	CN: 15-0191	In Lie Period: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet D-1 Date/Time Pre	
						5/30/2023 4:1	
	Cost Center Description	Total	Title	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient CostIr		9	9	(col. 3 x col.	
42.00	NUDCEDY (+: +I - V 0 VIVI ·)	1.00	2. 00	3. 00	4. 00	5. 00	12.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43. 00
44.00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
777.00	Cost Center Description	\					
40.00	Drogram i mosti ent ancillany comi co cost (William)	at D.2 and 2	line 200)			1. 00	40.00
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	84, 319 0	1
49. 00	Total Program inpatient costs (sum of lines				, coramir r)	425, 364	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from	ı Wkst. D, su	m of Parts I and	183, 821	50.00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	8, 179	51.00
E2 00	and IV)	E0 and E1)				100.000	E2 22
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	iding capital rela	ated, non-phy	rsician anest	hetist, and	192, 000 233, 364	1
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge						55. 00
55. 01	Permanent adjustment amount per discharge	uoo onlu)				0.00	55. 01 55. 02
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	1
57. 00	Difference between adjusted inpatient operat		get amount (I	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	l' 55 C			1, 4007	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost repo	orting period	ending 1996,	0.00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,		prior year o	ost report,	updated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of the	e amount by w	hich operati	ng costs (line	0	61. 00
	enter zero. (see instructions)	. 00), 01 1 % 01	ine target an	iodire (irrio o	o), otherwise		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instruct	tions)			0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see mistrue	11 0113)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	oer 31 of the	cost report	ing period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	- 31 of the c	nst renortin	n neriod (See	0	65. 00
03.00	instructions)(title XVIII only)	its arter becomber	or or the c	ost reportin	g perrou (see	O	03.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	1 plus line 6	5)(title XVI	<pre>II only); for</pre>	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through [December 31 d	of the cost r	eporting period	0	67. 00
	(line 12 x line 19)	J					
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	cember 31 of	tne cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N				\		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	•		•)		70.00
72.00	Program routine service cost (line 9 x line	71)					72. 00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74. 00 75. 00
73.00	26, line 45)	Toutine service (20313 (1101111	orksneet b,	rait II, corumii		73.00
76. 00	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	Aggregate charges to beneficiaries for exces		ovi der record	ls)			79.00
80.00	Total Program routine service costs for comp	arison to the cos			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi						81. 00 82. 00
82.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs ()				83.00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86.00
						64	87. 00
87. 00	Total observation bed days (see instructions						1
87. 00 88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	diem (line 27 ÷ l	ine 2)			6, 687. 16 427, 978	88. 00

Health Financial Systems	FRANCI SCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
		Title	XVIII	Hospi tal	PPS	
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	641, 570	1, 190, 315	0. 53899	2 427, 978	230, 677	90.00
91.00 Nursing Program cost	0	1, 190, 315	0.00000	0 427, 978	0	91.00
92.00 Allied health cost	0	1, 190, 315	0.00000	0 427, 978	0	92.00
93.00 All other Medical Education	0	1, 190, 315	0.00000	0 427, 978	0	93. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0191	Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Prep 5/30/2023 4:1	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
· ·			1, 00	

		Title XIX	Hospi tal	Cost	5 piii
	Cost Center Description				
	DADT I ALL DOOM DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		178	1. 00
2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		178	2.00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od days)		114	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	21 of the cost	0	7. 00
7.00	reporting period	r days) through becember	31 of the cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	1 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 newborn days) (see instructions)	the Program (excluding	swing-bed and	10	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	oom davs)	0	10.00
	through December 31 of the cost reporting period (see instruct				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	e i ooiii days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13.00
44.00	after December 31 of the cost reporting period (if calendar ye				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0.00	18. 00
10.00	reporting period		the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
20.00	reporting period	ditter becomber of or the	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			1, 190, 315	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporting	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		1, 190, 315	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	nus lina 33)(saa instruct	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		11 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	fferential (line	1, 190, 315	
200	27 minus line 36)	,		., ., , , , , ,	00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.25	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			, ,,,,	00.00
38. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			6, 687. 16	
39. 00 40. 00	Medically necessary private room cost applicable to the Progra	,		66, 872 0	
	Total Program general inpatient routine service cost (line 39	,		66, 872	
		•	'	- '	

Heal th	Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1	
						5/30/2023 4:1	
	Cost Center Description	Total	Ti t	le XIX Average Pe	Hospital r Program Days	Cost Program Cost	
	cost center bescription	Inpatient Cost	Inpatient Day	sDiem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Unit:						42.00
43. 00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	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 (W	/kst. D-3, col. 3	, line 200)			0	48. 00
48. 01	Program inpatient cellular therapy acquisit	ion cost (Worksh	eet D-6, Part		, column 1)	0	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instru	ctions)		66, 872	49.00
50. 00	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D. su	m of Parts I and	0	50.00
	[111)	•	•	•			
51. 00	Pass through costs applicable to Program in and IV)	patient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost excl		lated, non-ph	ysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	9 52)					1
54.00	Program di scharges					0	54.00
55. 00	Target amount per discharge					0.00	
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
56. 00	Target amount (line 54 x sum of lines 55, 5					0.00	1
57. 00	Difference between adjusted inpatient opera	ting cost and ta	rget amount (line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period	endi na 1996	0 0. 00	
	updated and compounded by the market basket)	·	0.			
60. 00	Expected costs (lesser of line 53 ÷ line 54 market basket)	, or line 55 fro	m prior year	cost report,	updated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	esser of 50% of t	he amount by	which operati	ng costs (line	0	61.00
	enter zero. (see instructions)						
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
64. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through Dece	mber 31 of th	e cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
// 00	instructions)(title XVIII only)		/	/E) /±: ±1 = \\\/		0	
66. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	The Costs (Time	64 prus rine	os)(title xvi	ii oniy); ioi	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)				or tring porrou		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER					0	69.00
70. 00	Skilled nursing facility/other nursing faci)		70.00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 x l	ine 35)			72.00
74. 00	Total Program general inpatient routine ser						74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital-related costs (line 9 x lin	e 76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		rovi den rocen	ds)			78. 00 79. 00
80.00	Total Program routine service costs for com			•	nus line 79)		80.00
81. 00	Inpatient routine service cost per diem lim	i tati on		-	,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs		•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see i	•	٠,				84.00
85.00	Utilization review - physician compensation	(see instructio					85.00
86. 00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA		rough 85)				86.00
87. 00	Total observation bed days (see instruction					64	87. 00
88.00	Adjusted general inpatient routine cost per	•	line 2)			6, 687. 16	
89. 00	Observation bed cost (line 87 x line 88) (s	on inctruction-				427, 978	

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2022	Worksheet D-1	
				To 12/31/2022		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	641, 570	1, 190, 315	0. 53899	2 427, 978	230, 677	90.00
91.00 Nursing Program cost	0	1, 190, 315	0.00000	0 427, 978	0	91.00
92.00 Allied health cost	0	1, 190, 315	0.00000	0 427, 978	0	92. 00
93.00 All other Medical Education	0	1, 190, 315	0.00000	0 427, 978	0	93.00

	ancial Systems FRANCISCAN BEACC ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0191	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
		Ti tl e	e XVIII	Hospi tal	PPS	5 piii
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
LUB	THENT POUTLING OFFICE OFFICE		1.00	2. 00	3. 00	
	ATIENT ROUTINE SERVICE COST CENTERS DO ADULTS & PEDIATRICS		1	122 014		20.00
	LLARY SERVICE COST CENTERS			133, 816		30.00
	OO OPERATI NG ROOM		0.0000	00 0	0	50.00
	OO RECOVERY ROOM		0. 00000		0	
	DO DELIVERY ROOM & LABOR ROOM		0. 00000		0	
	OO ANESTHESI OLOGY		0. 00000		0	
	DO RADI OLOGY-DI AGNOSTI C		0. 1647		12, 428	
	DO RADI OLOGY-THERAPEUTI C		0.0000		0	1
66.00 0560	DO RADI OI SOTOPE		0.0000	00 0	0	56.00
7. 00 0570	DO CT SCAN		0.00000	00	0	57.0
8. 00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)		0.00000	00	0	58.00
59.00 0590	DO CARDI AC CATHETERI ZATI ON		0.0000	00	0	59. 0
	DO LABORATORY		0. 23692		34, 008	60.0
	D1 BLOOD LABORATORY		0.00000		0	
	OO PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	
	OO WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	
	DO BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	
	DO I NTRAVENOUS THERAPY		0.00000		0	
	DO RESPI RATORY THERAPY		0.00000		0	
	DO PHYSI CAL THERAPY		0.00000		0	
	OO OCCUPATIONAL THERAPY		0.00000		0	67. 0
	DO SPEECH PATHOLOGY DO ELECTROCARDI OLOGY		0. 00000 0. 0465!		3, 007	
	DO ELECTROCARDI OLOGI DO ELECTROENCEPHALOGRAPHY		0.0000		3,007	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
	DO IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	1
4	DO DRUGS CHARGED TO PATIENTS		0. 2173		9, 682	1
4	DO RENAL DI ALYSI S		0. 00000		9, 002	1
	DO ASC (NON-DISTINCT PART)		0. 00000		0	
	OO ALLOGENEIC STEM CELL ACQUISITION		0. 00000		0	
	PATIENT SERVICE COST CENTERS		0.0000	30 3	0	77.0
	DO CLI NI C		0.0000	00 0	0	90.0
	DO EMERGENCY		0. 3566		25, 194	
	OO OBSERVATION BEDS (NON-DISTINCT PART)		2. 79700		0	1
200.00	Total (sum of lines 50 through 94 and 96 through 98)			398, 759	84, 319	
201. 00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0	*	201. 0
202.00	Net charges (line 200 minus line 201)			398, 759		202. 0

ALTH FINANCIAL SYSTEMS FRANCISCAN BEAC PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0191	Peri od:	Worksheet D-3	3
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 O3000 ADULTS & PEDIATRICS			89, 035		30
ANCI LLARY SERVI CE COST CENTERS					4
OO 05000 OPERATING ROOM		0.0000		0	
00 05100 RECOVERY ROOM		0.0000		0	
OO O5200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
00 05300 ANESTHESI OLOGY		0.0000		0	
. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1647		0	
00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
00 05600 RADI 0I SOTOPE		0.0000		0	
. 00 05700 CT SCAN		0.0000		0	
00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0.0000		0	
00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
00 06000 LABORATORY		0. 2369		0	
01 06001 BLOOD LABORATORY		0.0000		0	
00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY		0.0000		0	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
.00 06300 BLOOD STORING, PROCESSING & TRANS. .00 06400 NTRAVENOUS THERAPY		0.0000		0	1
				0	
.00 06500 RESPI RATORY THERAPY .00 06600 PHYSI CAL THERAPY		0.0000		0	
		0.0000		_	1
. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	1
. 00 06800 SPEECH PATHOLOGY		0.0000		0	
. 00 06900 ELECTROCARDI OLOGY . 00 07000 ELECTROENCEPHALOGRAPHY		0. 0465 0. 0000		0	
.00 07000 ELECTROENCEPHALOGRAPHY .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	1
		0.0000		0	
		1		_	
.00 07300 DRUGS CHARGED TO PATIENTS .00 07400 RENAL DI ALYSIS		0. 2173		0	
00 07500 ASC (NON-DISTINCT PART)		0.0000		0	
.00 07300 ALLOGENEIC STEM CELL ACQUISITION		0.0000		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	U	4 ′′
00 09000 CLINIC		0.0000	00 0	0	90
. 00 09100 EMERGENCY		0. 3566		0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 7970		0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)		2. /9/0	04	_	200
1.00 Less PBP Clinic Laboratory Services-Program only charge	os (lino 61)			0	201
2.00 Net charges (line 200 minus line 201)	=5 (IIIIE 0I)		0		201

	Title XVIII Hospital	5/30/2023 4: 1 PPS	5 pm
	DADT A LABATIENT HOODITAL CERVICOSC UNDER LODG	1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	131, 192	1
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	43, 731	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octob	per 0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 01 2. 02
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	
2. 04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	1
3.00	Managed Care Simulated Payments	0	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	7. 82	4. 00
	Indirect Medical Education Adjustment		
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending or before 12/31/1996. (see instructions)	on 0.00	5. 00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap 1	or 0.00	6. 00
()(new programs in accordance with 42 CFR 413.79(e)		/ 2/
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 (the CAA 2021 (see instructions)	of 0.00	6. 26
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	•	1
	cost report straddles July 1, 2011 then see instructions.		
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)		7. 02
	and 87 FR 49075 (August 10, 2022) (see instructions)		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the co	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
0. 02	under § 5506 of ACA. (see instructions)	0.00	0.02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0.00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
	FTE count for residents in dental and podiatric programs.	0.00	1
12. 00	Current year allowable FTE (see instructions)	•	12. 00
13.00	Total allowable FTE count for the prior year.	0.00	1
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 199	0.00	14. 00
	otherwise enter zero.		
15. 00	Sum of lines 12 through 14 divided by 3.		15. 00
	Adjustment for residents in initial years of the program (see instructions)		16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	•	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	
	Prior year resident to bed ratio (see instructions)	0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)	0. 000000	1
	IME payment adjustment (see instructions)	0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	0.00	24 00
24. 00 25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0.00	1
23.00	instructions)	0.00	25.00
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)	0	1
	IME add-on adjustment amount - Managed Care (see instructions)	0	1
29. 00	Total IME payment (sum of lines 22 and 28)	0	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	0.00	1
32. 00	Sum of lines 30 and 31	0.00	1
33. 00	Allowable disproportionate share percentage (see instructions)	0.00	
34.00	Disproportionate share adjustment (see instructions)	0	34. 00

	Financial Systems FRANCISCAN BEACC ATION OF REIMBURSEMENT SETTLEMENT	ON HOSPITAL Provider CCN: 15-0191	Peri od:	u of Form CMS-2 Worksheet E	2552-
LOUL	ATTOM OF RETWINDINGSEMENT SETTEEMENT	Trovider con. 15 6171	From 01/01/2022 To 12/31/2022	Part A Date/Time Pre	pared
		Title XVIII	Hospi tal	5/30/2023 4: 1! PPS	5 pm
		I tre will	Pri or to 10/1		
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
. 00	Total uncompensated care amount (see instructions)		0 00000000	0	35. (
. 01 . 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero,	ontor zoro on this line	0. 000000000	0. 000000000 0	35. (35. (
. 02	(see instructions)	, enter zero on this inte	0	U	33.
. 03	Pro rata share of the hospital UCP, including supplemental UCP	CP (see instructions)	0	0	35.
. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		0		36.
00	Additional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 throu			40
. 00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40. 41.
. 01	Total ESRD Medicare covered and paid discharges (see instructions)	tions)	0		41.
. 00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42.
. 00	Total Medicare ESRD inpatient days (see instructions)		0		43.
. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
. 00	days) Average weekly cost for dialysis treatments (see instructions	e)	0.00		45.
	Total additional payment (line 45 times line 44 times line 4		0.00		46.
. 00	Subtotal (see instructions)		174, 923		47.
. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48.
	only. (see instructions)				
				Amount 1.00	
. 00	Total payment for inpatient operating costs (see instructions	s)		174, 923	49.
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a			12, 980	50.
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	The 49 see Instructions).		0	52. 53.
. 00	Special add-on payments for new technologies			0	54.
. 01	Islet isolation add-on payment			0	54.
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.
. 01	Cellular therapy acquisition cost (see instructions)			0	55.
. 00	Cost of physicians' services in a teaching hospital (see int	•	-bb 2F)	0	56.
. 00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.		inrough 35).	0	57. 58.
. 00	Total (sum of amounts on lines 49 through 58)	1V, Cor. 11 111le 200)		187, 903	59.
. 00	Primary payer payments			0	60.
. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		187, 903	61.
. 00	Deductibles billed to program beneficiaries			29, 564	62.
. 00	Coinsurance billed to program beneficiaries			0	63.
. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	64. 65.
. 00	1 - 7	tructions)		0	66.
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			158, 339	
. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	see instructions)	0	68.
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	.(For SCH see instruction	ns)	0	69.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.
. 50 . 75	Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions)	tration) adjustment (see	Instructions)	0	70. 70.
. 73	Demonstration payment adjustment amount (see instructions)			0	70.
. 88	SCH or MDH volume decrease adjustment (contractor use only)			Ö	70.
. 89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			70.
. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.
. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.
. 92	Bundled Model 1 discount amount (see instructions)			0	70.
. 93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0	70. 70.
94				U	,

Heal th	Financial Systems FRANCISCAN BEACO	N HOSPITAL		In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	_		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A	pared:
		Title	e XVIII	Hospi tal	PPS	о рііі
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				0	1
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			158, 339	
71. 01	Sequestration adjustment (see instructions)				1, 995	1
71. 02	Demonstration payment adjustment amount after sequestration				0	1
71. 03	Sequestration adjustment-PARHM or CHART pass-throughs				157 577	71. 03
	Interim payments				157, 577	
73. 00	Interim payments-PARHM or CHART Tentative settlement (for contractor use only)				0	72. 01 73. 00
73. 00	Tentative settlement (for contractor use only) Tentative settlement-PARHM or CHART (for contractor use only)	1			U	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	,			-1, 233	
74.00	73)	2, 72, and			-1, 233	74.00
74. 01	Balance due provider/program-PARHM or CHART (see instructions)				74. 01
75. 00	Protested amounts (nonallowable cost report items) in accorda				0	
73.00	CMS Pub. 15-2, chapter 1, §115.2	nee wi tii			0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr	ucti ons)			0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instruc				0	
94. 00	The rate used to calculate the time value of money (see instr	ucti ons)			0. 00	•
95. 00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruc	tions)		T	0	96. 00
					On/After 10/1	
	HSP Bonus Payment Amount			1. 00	2. 00	
100 00	HSP bonus amount (see instructions)			O	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			<u> </u>	0	1100.00
101 00	HVBP adjustment factor (see instructions)			0.0000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0.000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment	3)		<u> </u>	0	102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
	HRR adjustment amount for HSP bonus payment (see instructions)		0.0000		104. 00
2 00	Rural Community Hospital Demonstration Project (§410A Demonst		ıstment	<u> </u>		1
200.00	Is this the first year of the current 5-year demonstration pe					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement			· '		
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	e 49)				201. 00
202.00	Medicare discharges (see instructions)					202. 00
202 00	Case-mix adjustment factor (see instructions)					203.00
203.00	Computation of Demonstration Target Amount Limitation (N/A in					<u> 1</u> 200. 00

	73)			
74. 01	Balance due provider/program-PARHM or CHART (see instructions)			74.0
75. 00	Protested amounts (nonallowable cost report items) in accordance with		0	1
	CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. (
	plus 2.04 (see instructions)			
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91. (
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92. (
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	93. (
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94. (
95. 00	Time value of money for operating expenses (see instructions)		0	95. (
96. 00	Time value of money for capital related expenses (see instructions)		0	96. (
		Prior to 10/1	On/After 10/1	
		1. 00	2. 00	
	HSP Bonus Payment Amount			
00.0	HSP bonus amount (see instructions)	0	0	100. (
	HVBP Adjustment for HSP Bonus Payment			
01.0	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101. (
02.0	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.
	HRR Adjustment for HSP Bonus Payment			
03.0	HRR adjustment factor (see instructions)	0.0000	0.0000	103.
04.0	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
00.0	Is this the first year of the current 5-year demonstration period under the 21st			200. (
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			
01.0	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. (
02. 0	Medicare discharges (see instructions)			202. (
03.0	Case-mix adjustment factor (see instructions)			203. (
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current	t 5-year demonst	tration	
	peri od)	_		
	Medicare target amount			204. (
	Case-mix adjusted target amount (line 203 times line 204)			205. (
06.0	Medicare inpatient routine cost cap (line 202 times line 205)			206. (
	Adjustment to Medicare Part A Inpatient Reimbursement			
	Program reimbursement under the §410A Demonstration (see instructions)			207. (
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.
	Adjustment to Medicare IPPS payments (see instructions)			209.
	Reserved for future use			210.
11. 0	Total adjustment to Medicare IPPS payments (see instructions)			211.
	Comparision of PPS versus Cost Reimbursement			
	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.
			1	213. (
213. 0	Low-volume adjustment (see instructions)			
213. 0	Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218. (

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-01	From 01/01/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 4:15 pm

		Title XVIII	Hospi tal	5/30/2023 4: 15 PPS	5 PIII
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			233	1. 00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ons)		1, 792, 722 1, 135, 983	2. 00 3. 00
4. 00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0. 000	5. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			233	11. 00
	Reasonable charges				
12.00	Ancillary service charges			1, 072	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			1, 072	14. 00
15. 00	Aggregate amount actually collected from patients liable for pay	vment for services on a	charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for p		•	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 1, 072	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	ne 11) (see	839	19. 00
	instructions)		, (
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			233	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			1, 135, 983	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 2	24 (for CAH, see instru	uctions)	228, 516	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu			907, 700	27. 00
	instructions)	50)			
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)	e 50)		0 0	28. 00 29. 00
30. 00	Subtotal (sum of lines 27 through 29)			907, 700	
31. 00	Primary payer payments			646	31. 00
32. 00	Subtotal (line 30 minus line 31)	**		907, 054	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES Composite rate ESRD (from Wkst. I-5, line 11)	o)		0	33. 00
34. 00	Allowable bad debts (see instructions)			17, 214	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			11, 189	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		12, 545	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			918, 243 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	d dovisos (soo instruct	i ons)	0	39. 97
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see ilistruct	.1 0115)		39. 98 39. 99
40. 00	Subtotal (see instructions)			918, 243	40.00
40. 01	Sequestration adjustment (see instructions)			11, 570	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			894, 941	40. 03 41. 00
41. 01	Interim payments Interim payments-PARHM or CHART			074, 741	41. 01
42.00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)				42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			11, 732	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2. o	chapter 1.	o	44. 00
00	§115. 2				55
	TO BE COMPLETED BY CONTRACTOR				
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money			0. 00	91.00
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0191	Peri od:	Worksheet E	
		From 01/01/2022		
		To 12/31/2022	Date/Time Pr	epared:
			5/30/2023 4:	15 pm
	Title XVIII	Hospi tal	PPS	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			(0 200. 00

Provider CCN: 15-0191

				10 12,01,2022	5/30/2023 4: 15	5 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		157, 57	77	894, 941	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,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					ĺ
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provi der to Program			_	_	
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	
3. 52 3. 53				0	0	3. 52 3. 53
3. 53				0		3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
3. 77	3. 50-3. 98)			٩] 3. //
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		157, 57	77	894, 941	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02	TENTATIVE TO TROVIDER			0		5. 02
5. 03				o	0	5. 03
	Provider to Program			-,		
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	11, 732	6. 01
6. 02	SETTLEMENT TO PROVIDER		1, 23	-	11, 732	6. 02
7.00	Total Medicare program liability (see instructions)		156, 34		906, 673	
, . 50	1.5 ca. modification program frability (300 fristructions)		130, 32	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems	FRANCISCAN BEACON	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0191	Peri od:	Worksheet E-1	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
		Title XVIII	Hospi tal	PPS	і э рііі
			noopi tui		
				1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA	RD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION	ON AND CALCULATION				1
1.00 Total hospital discharges as defined in AAR	A §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, co	l. 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 Wk	st. S-10, col. 3 li	ne 20			6. 00
7.00 CAH only - The reasonable cost incurred for	the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
line 168					
8.00 Calculation of the HIT incentive payment (s	ee instructions)				8. 00
9.00 Sequestration adjustment amount (see instru	ctions)				9. 00
10.00 Calculation of the HIT incentive payment af	ter sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS	k CAH				
30.00 Initial/interim HIT payment adjustment (see	instructions)				30.00
31.00 Other Adjustment (specify)					31. 00
32.00 Balance due provider (line 8 (or line 10) m	nus line 30 and li	ne 31) (see instruction	s)		32. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0191		Worksheet E-3 Part VII Date/Time Prepared: 5/30/2023 4:15 pm

			10 12/31/2022	5/30/2023 4: 1	5 pm
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		66, 872		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		66, 872	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		66, 872	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges		00.005		
8.00	Routine service charges		89, 035		8. 00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10. 00 11. 00
11.00	Incentive from target amount computation		١	0	
12. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		89, 035	U	12. 00
13. 00	Amount actually collected from patients liable for payment for	s convices on a charge	l	0	13. 00
13.00	basis	services on a charge	٩	U	13.00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with			٥١	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 011 3110. 10(0)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		89, 035	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	v if line 16 exceeds	22, 163	0	17. 00
	line 4) (see instructions)		,		
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)			ļ	
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see inst		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line		66, 872	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	ļ	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00 28. 00
28. 00 29. 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		66, 872	0	28.00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		00, 072	U	29.00
30. 00	Excess of reasonable cost (from line 18)			0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		66, 872	0	31. 00
32. 00	Deductibles	'	00, 072	0	32. 00
33. 00	Coinsurance			0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0	١	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	66, 872	0	36. 00
37. 00			0	0	37. 00
38. 00	, , , , ,		66, 872	0	38. 00
39. 00			0	- 1	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		66, 872	0	40. 00
41.00	Interim payments		29, 352	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		37, 520	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Heal th	Financial Systems FRANCISCAN B	EACON HOSPITAL	In Lie	eu of Form CMS-2552-10	
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0191 Period:		Worksheet E-5			
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 4:15	
		Title XVIII		PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR					
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)			0	4.00	
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00 Time value of money for operating expenses (see instructions)				0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

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

Provider CCN: 15-0191

oni y)					5/30/2023 4:1	5 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4.00	
	CURRENT ASSETS		J	J .		
1.00	Cash on hand in banks	8, 214, 819		0	0	
2. 00 3. 00	Temporary investments	0		-	0	
4.00	Notes recei vabl e Accounts recei vabl e	3, 986, 009	1		0	
5.00	Other recei vable	3, 760, 007			0	
6.00	Allowances for uncollectible notes and accounts receivable	-2, 908, 585			0	
7. 00	Inventory	161, 048			Ö	
8. 00	Prepaid expenses	344, 673		o o	Ō	
9.00	Other current assets	0		0	0	9. 00
10.00	Due from other funds	0) (0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9, 797, 964	. (0	0	11. 00
	FIXED ASSETS					
12.00	Land	1, 514, 351	1			1
13.00	Land improvements	42, 865	1	-	1	
14. 00	Accumulated depreciation	-10, 716	•	0		
15. 00	Bui I di ngs	18, 857, 743	1	0	0	
16. 00	Accumulated depreciation	-1, 237, 076	1	0	0	
17. 00	Leasehold improvements	0		0	0	
18.00	Accumulated depreciation	0		0	0	
19.00	Fixed equipment	0		0	0	
20.00	Accumulated depreciation	0		0	0	
21.00	Automobiles and trucks	0	1	0	0	
22. 00	Accumulated depreciation	4 (7 420	1	0	0	
23. 00	Maj or movable equipment	4, 667, 428		0	0	
24. 00 25. 00	Accumul ated depreciation Minor equipment depreciable	-2, 073, 540			0	
26. 00	Accumulated depreciation				0	
27. 00	HIT desi gnated Assets				0	
28. 00	Accumulated depreciation				0	
29. 00	Mi nor equi pment-nondepreci abl e		1		0	
30.00	Total fixed assets (sum of lines 12-29)	21, 761, 055	1			
00.00	OTHER ASSETS	21,701,000	1	<u> </u>		00.00
31.00	Investments	0) (0	0	31.00
32.00	Deposits on Leases	0		0	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	Total assets (sum of lines 11, 30, and 35)	31, 559, 019)	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	374, 894	1	0		1
38. 00	Salaries, wages, and fees payable	234, 567	1	0	ı	
39. 00	Payroll taxes payable	17, 944	. (0	0	
40.00	Notes and Loans payable (short term)	0		0	0	
41.00	Deferred income	63, 764		0	0	
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds	16, 656, 413		0	0	
44.00	Other current liabilities	0	1	0 0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	17, 347, 582		0	0	45. 00
46. 00	Mortgage payable				0	46. 00
47. 00	Notes payable		1			
48. 00	Unsecured Loans		1		l	1
49. 00	Other long term liabilities	0	1		Ö	
50. 00	Total long term liabilities (sum of lines 46 thru 49)	0		-	l	
51.00	Total liabilities (sum of lines 45 and 50)	17, 347, 582		o o	l	
	CAPITAL ACCOUNTS	, , , , , , , , , , , , , , , , , , , ,				
52.00	General fund balance	14, 211, 437	1			52.00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant		1		0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	14, 211, 437		0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and	31, 559, 019	ď	0	0	60. 00
	[59]	I	I	1	l	I

STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 15-0191

Peri od: Worksheet G-1 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/30/2023 4:15 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 17, 565, 190 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -3, 353, 754 2.00 3.00 Total (sum of line 1 and line 2) 14, 211, 436 0 3.00 4.00 ROUNDI NG 0 0 4.00 5.00 0 0 0 0 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 14, 211, 437 Subtotal (line 3 plus line 10) 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 14, 211, 437 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 ROUNDI NG 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00 sheet (line 11 minus line 18)

Health Financial Systems FISTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0191

			10 12/31/2022	5/30/2023 4:1	
	Cost Center Description	I npati ent	Outpati ent	Total	Б
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	252, 15	9	252, 159	1. 00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		o	0	5. 00
6.00	Swing bed - NF		o	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)	252, 15	9	252, 159	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				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of line		0	0	16. 00
10.00	11-15)	.5		o l	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	252, 15	9	252, 159	17. 00
18. 00	Ancillary services	666, 09		25, 239, 600	18. 00
19. 00	Outpati ent servi ces		8, 853, 569	8, 853, 569	19. 00
20. 00	RURAL HEALTH CLINIC	1	0, 033, 307	0, 033, 307	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		5	U	22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W	/kst. 918, 25	7 33, 427, 071	34, 345, 328	28. 00
20.00	G-3, line 1)	710, 25	33, 427, 071	34, 343, 320	20.00
	PART II - OPERATING EXPENSES	I			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		11, 101, 927		29. 00
30. 00	ADD (SPECIFY)		0		30.00
31. 00	(0.2011)		0		31. 00
32. 00		I	n n		32. 00
33. 00			Ö		33. 00
34. 00			o o		34. 00
35. 00			Ö		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		n o		37. 00
38. 00	DEBOOT (SECTITY)		o o		38. 00
39. 00			o o		39. 00
40. 00			0		40. 00
41. 00)		41. 00
41.00	Total deductions (sum of lines 37-41)				41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	ansfer	11, 101, 927		43. 00
45.00	to Wkst. G-3, line 4)	413101	11, 101, 727		73.00
	TO MASE. O O, TITLE T)	ı	1		1

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10					
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0191 Period:			Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, I			34, 345, 328	
2.00	Less contractual allowances and discounts on patients' acco	unts		26, 603, 660	
3.00	Net patient revenues (line 1 minus line 2)			7, 741, 668	
4.00	Less total operating expenses (from Wkst. G-2, Part II, lin	e 43)		11, 101, 927	
5. 00	Net income from service to patients (line 3 minus line 4)			-3, 360, 259	5. 00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8. 00	Revenues from telephone and other miscellaneous communicati	on services		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	
11. 00				0	
	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			4, 945	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE			1, 560	24. 00
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (sum of lines 6-24)			6, 505	25. 00
	Total (line 5 plus line 25)			-3, 353, 754	
	OTHER EXPENSES (SPECIFY)			0	1
	00 Total other expenses (sum of line 27 and subscripts)			0	28. 00
	00 Net income (or loss) for the period (line 26 minus line 28)			-3, 353, 754	29 00

Heal th	Financial Systems FRANCISCAN BEACO	N HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0191	Peri od: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 5/30/2023 4:1	pared:
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCEETIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				-
1. 00	Capital DRG other than outlier			12, 980	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier		12, 700		
2.00	Capital DRG outlier payments			0	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	0. 31	
4.00	Number of interns & residents (see instructions)		,	0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	E, part A line	0. 00	7. 00
0.00	30) (see instructions)	inti ana)		0.00	8.00
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instru Sum of lines 7 and 8	ictions)		0.00	
10. 00	Allowable disproportionate share percentage (see instructions	-)			10.00
11. 00				0.00	
12. 00	, , , , , , , , , , , , , , , , , , , ,			_	12. 00
12.00	prospective eapital paymente (eee metraetrens)			127 700	12.00
	DART LL DAVINENT UNDER REACONARIE COCT			1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST			0	1.00
1. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	,			0	
5. 00					5. 00
	DART III COMPUTATION OF EVERTION DAVMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2. 00		cas (saa instructions)		0	
3.00					3.00
4. 00					4. 00
5. 00					5. 00
6.00					6. 00
7.00	Adjustment to capital minimum payment level for extraordinary		(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)		·	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to c			0	
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital pa	avments (line 10 nlus lin	ne 11)	0	12. 00
13. 00					
14. 00	Carryover of accumulated capital minimum payment level over of	0			
55	(if line 12 is negative, enter the amount on this line)	rai payone roi the r	porrou		55
15. 00					
16.00	Current year operating and capital costs (see instructions)	•		0	16. 00
17. 00	Current year exception offset amount (see instructions)			0	17. 00