This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0191 Worksheet S Peri od: From 03/24/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/31/2022 2:38 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/31/2022 2:38 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 or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN BEACON HOSPITAL (15-0191) for the cost reporting period beginning 03/24/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Am	y Herron	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Amy Herron			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
P	PART III - SETTLEMENT SUMMARY						
1.00 F	Hospi tal	0	121, 163	4, 579	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
200.00 1	Total	0	121, 163	4, 579	0	0	200. 00

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

Health Financial Systems 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 03/24/2021 Part I 12/31/2021 Date/Time Prepared: 5/31/2022 2:38 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 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) 03/24/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 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 uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N

N

Ν

3

Ν

Ν

N

22.03

22.04

23 00

Ν

Ν

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

rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

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.

22.03 Did this hospital receive a geographic reclassification from urban to

22.04 Did this hospital receive a geographic reclassification from urban to

23 00

October 1.

yes or "N" for no.

yes or "N" for no.

58 00

59.00

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

			CON HOSPITAL			u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	Fi	eriod: rom 03/24/2021	Worksheet S-2 Part I	
				To		Date/Time Prep 5/31/2022 2:38	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		/		1.00	2. 00	3. 00	
60. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1	N			60.00
		Y/N	IME	Direct GME	I ME	Direct GME	
61. 00	Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	5.00	61. 00
01.00	section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	01.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. 05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	part or general sargery. (ess merraetrons)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61 10	Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 10
01. 10	special ty, 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.				0.00	0. 33	01. 10
61. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
						1. 00	
62.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which		62. 00
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62. 01
63. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co	67. (see instru	ictions)	N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi (der Settings	1.00 This base year	2.00 is your cost r	3.00 eporting	
64. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	re June cy trair n-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00			64. 00
	of (column 1 divided by (column 1 + column 2)). (see	instruc	ctions)	I			

	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	3. 00	
	Inpatient Psychiatric Facility P	PPS					1 2. 00	0.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does it conta	ain an IPF subp	rovi der?	N			70. 00
	Enter "Y" for yes or "N" for no								
71. 00	If line 70 is yes: Column 1: Did							0	71. 00
	recent cost report filed on or b								
	42 CFR 412. 424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF Column 3: If column 2 is Y, indi								
	(see instructions)	cate which program ye	ear began durring this	cost reporting	perrou.				
	Inpatient Rehabilitation Facilit	y DDS							
75 00	Is this facility an Inpatient Re		(IRE) or does it co	ontain an IRE		N			75. 00
	subprovider? Enter "Y" for yes		, (),			''			
76.00	If line 75 is yes: Column 1: Did		n approved GME teachir	ng program in t	he most			0	76. 00
	recent cost reporting period end								
	no. Column 2: Did this facility								
	CFR 412.424 (d)(1)(iii)(D)? Ente								
	indicate which program year bega	in during this cost re	eporting period. (see	instructions)					
WCBI E3	2 - 17.4.174.1								
OITI J	£ 17. 1. 177. 1								

OSPITAL A	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021		repared	
					5/31/2022 2	: 38 pm	
	T. O. H. I.I. DDC				1. 00		
	g Term Care Hospital PPS this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for	no		N	80. 0	
1.00 Is "Y"	this a LTCH co-located within another hospital for part or for yes and "N" for no.			ng period? Enter	N	81. 0	
5. 00 Is	RA Providers this a new hospital under 42 CFR Section §413.40(f)(1)(i) this facility establish a new Other subprovider (excluded				N	85. (86. (
§41:	3.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. this hospital an extended neoplastic disease care hospital	ŕ			N	87.	
1886	6(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				VI V		
				1. 00	2. 00		
Ti tl	le V and XIX Services			1.00	2.00		
	s this facility have title V and/or XIX inpatient hospital or "N" for no in the applicable column.	servi ces? E	nter "Y" for	N	Y	90.	
.00 Ís	this hospital reimbursed for title V and/or XIX through th			N	Y	91.	
2.00 Are	l or in part? Enter "Y" for yes or "N" for no in the appli title XIX NF patients occupying title XVIII SNF beds (dua	l certificat			N	92.	
	tructions) Enter "Y" for yes or "N" for no in the applicab s this facility operate an ICF/IID facility for purposes o		d XIX? Enter	N	N	93.	
	for yes or "N" for no in the applicable column. s title V or XIX reduce capital cost? Enter "Y" for yes, a	ınd "N" for n	o in the	N	N	94.	
	licable column.	i aabla aalum	-	0.00	0.00	95.	
. 00 Does	line 94 is "Y", enter the reduction percentage in the appl s title V or XIX reduce operating cost? Enter "Y" for yes			N N	N N	96.	
1	licable column. line 96 is "Y", enter the reduction percentage in the appl	icable colum	n.	0. 00	0.00	97.	
Does	00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in						
. 01 Does	umn 1 for title V, and in column 2 for title XIX. s title V or XIX follow Medicare (title XVIII) for the rep Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit		Y	98.			
titl 3.02 Does	title XIX. 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						
. 03 Does	title V, and in column 2 for title XIX. s title V or XIX follow Medicare (title XVIII) for a criti mbursed 101% of inpatient services cost? Enter "Y" for yes				N	98.	
. 04 Does	title V, and in column 2 for title XIX. s title V or XIX follow Medicare (title XVIII) for a CAH r patient services cost? Enter "Y" for yes or "N" for no in			N d	N	98.	
. 05 Does	column 2 for title XIX. s title V or XIX follow Medicare (title XVIII) and add bac t. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co	k the RCE di Jumn 1 for t	sallowance on itle V, and i	n Y	Y	98.	
Does Pts.	umn 2 for title XIX. s title V or XIX follow Medicare (title XVIII) when cost r . I through IV? Enter "Y" for yes or "N" for no in column umn 2 for title XIX.			Y	Y	98.	
Rura	al Providers						
6.00 If	s this hospital qualify as a CAH? this facility qualifies as a CAH, has it elected the all-i	nclusive met	hod of payme	nt N		105. 106.	
7. 00 Col ı trai	outpatient services? (see instructions) umn 1: If line 105 is Y, is this facility eligible for cos ining programs? Enter "Y" for yes or "N" for no in column	1. (see ins	tructions)			107.	
аррі	umn 2: If column 1 is Y and line 70 or line 75 is Y, do y roved medical education program in the CAH's excluded IPF er "Y" for yes or "N" for no in column 2. (see instructio	and/or IRF					
8.00 ls	this a rural hospital qualifying for an exception to the C Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 4	2 N		108.	
		Physi cal	Occupation		Respi rator	У	
0 0015	this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2.00 N	3. 00 N	4.00 N	109.	
the	rapy services provided by outside supplier? Enter "Y" yes or "N" for no for each therapy.	IN .	IN	IV	IV.	109.	
0 00 014	this hospital participate in the Rural Community Hospital	Demonstrati	on project (S/10A	1. 00 N	110.	
	this nospital participate in the Rufal Community HOSDITAL	ווסוווסנו אנו	տութուտյ ԵՄՆ (։	y + IUM	i IN	μιιυ.	

alth Financial Systems FRANCISCAN BEAG SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	CON HOSPITAL Provider CO	N: 15-0191	Peri od:	u of Form CMS Worksheet S-	
			From 03/24/2021 To 12/31/2021	Part I Date/Time Pr	
				5/31/2022 2:	38 pm
1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this construction for yes or "N" for no in column 1. If the response to consider the column in the case of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for action tele-health services.	ost reporting polumn 1 is Y, e rticipating in	period? Enter enter the column 2.	1.00 N	2.00	111. (
		1. 00	2. 00	3.00	
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable. Mi scellaneous Cost Reporting Information	period? s "Y", enter ne	N			112.
5.00 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, E in column 2. If column 2 is "E", enter in column 3 either "S 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.	3, or E only) 93" percent (includes	N			0115.
6.00 s this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.
7.00 s this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	rance? Enter	Y			117.
8.00 is the mailpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			1		118.
The portey is craim made. Enter 2 in the portey is deed in	ence.	Premi ums	Losses	Insurance	
		1.00			
8.01 List amounts of malpractice premiums and paid losses:		1. 00	2. 00 1 C	3.00	0118.
			1. 00	2.00	-
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualid Hold Harmless provision in ACA §3121 and applicable amendments.	dule listing co d Harmless prov n column 1, "Y" ualifies for th	ost centers vision in ACA for yes or ne Outpatient		N	118. 119. 120.
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla	antable devices	charged to	N		121.
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1					122.
the Worksheet A line number where these taxes are included. Transplant Center Information					
5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If	N		125.
0.00 f this is a Medicare certified kidney transplant center, er		ication date	•		126
in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified heart transplant center, ent	ter the certifi	cation date			127
in column 1 and termination date, if applicable, in column 2 1.00 If this is a Medicare certified liver transplant center, ent	ter the certifi	cation date			128
in column 1 and termination date, if applicable, in column 2 2.00 f this is a Medicare certified lung transplant center, enter		ation date i	n		129
column 1 and termination date, if applicable, in column 2.					130
date in column 1 and termination date, if applicable, in col .00 f this is a Medicare certified intestinal transplant center	umn 2.				131
date in column 1 and termination date, if applicable, in col	umn 2.				
2.00 f this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2		cation date			132.
 OO Removed and reserved OO If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2. 	ne OPO number i	n column 1			133
ALL Drayi days					
All Providers 0.00 Are there any related organization or home office costs as of the costs are costs.	defined in CMS	Pub. 15-1	N		140.

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 03/24/2021 Part I 12/31/2021 Date/Time Prepared: To 5/31/2022 2:38 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00

li easonable cost i ilicuit eu toi tile ili i assets (see i ilstructions)			1
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	0.00	169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting			170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	C	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

reasonable cost incurred for the HIT assets (see instructions)

	FRANCISCAN BEA L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0191	Peri od:	worksheet S-2	
	2 1.10 1.00 1.11 1.21 1.11 0 1.11 1.11 1	11011461		From 03/24/2021 To 12/31/2021	Part II Date/Time Pre	epare
				V//NI	5/31/2022 2:3	38 pm
				Y/N 1. 00	2. 00	+
(General Instruction: Enter Y for all YES responses. Enter N	for all NO re	enoneae Enta			
n	nm/dd/yyyy format.	101 211 110 16	эропзез. спте	arr dates in	THE .	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
ю Г	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			
			Y/N	Date	V/I	
0 1	Use the provider terminated participation in the Medicara F)rogram2 lf	1.00	2. 00	3. 00	1
	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2
	ls the provider involved in business transactions, includir	ng management	N			3
	contracts, with individuals or entities (e.g., chain home o					
	or medical supply companies) that are related to the provid	ler or its				
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	inancial Data and Reports					
	Column 1: Were the financial statements prepared by a Cert		N			4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	iiiabie in				
	Are the cost report total expenses and total revenues diffe	erent from	N			5
	those on the filed financial statements? If yes, submit rec	onciliation.				
				Y/N	Legal Oper.	
1	Approved Educational Activities			1. 00	2. 00	+
	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If ves is	the provider	N		1 6
	is the legal operator of the program?	2. 11 you, 10	, the provider	**		~
o	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		N		7
	Were nursing programs and/or allied health programs approve	ed and/or renew	ed during the	N		8
	cost reporting period? If yes, see instructions.	araduata madia	al advaation	N		_
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructior		ai education	N		9
	Was an approved Intern and Resident GME program initiated o		he current	N		10
	cost reporting period? If yes, see instructions.					
	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.				\/ /N	
					1. 00	
E	Bad Debts				1.00	
00 [Is the provider seeking reimbursement for bad debts? If yes	, see instruct	i ons.		Υ	7 12
	If line 12 is yes, did the provider's bad debt collection p	olicy change o	luring this co	st reporting	N	13
	period? If yes, submit copy.		!	A	N.	1,4
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents warveu? II	yes, see ms	tructions.	l N	14
	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructi ons.	N	15
·	-		t A		t B	
		Y/N	Date	Y/N	Date	
Tr.	DCUD Data	1. 00	2.00	3. 00	4. 00	-
	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	02/24/2022	Υ	02/24/2022	16
	If either column 1 or 3 is yes, enter the paid-through		02/21/2022		02,21,2022	'
	date of the PS&R Report used in columns 2 and 4 .(see					
- 1	instructions) Was the cost report prepared using the PS&R Report for	N		N		17
	totals and the provider's records for allocation? If	IN		IN .		' '
- 1	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
		1	1	1	I	1
- 1	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19

Heal th	Financial Systems FRANCISCAN BEA	ACON HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pr 5/31/2022 2:	repared:
		Descri	pti on	Y/N	Y/N	JO PIII
		C		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 1.00	Date 2.00	Y/N 3. 00	Date 4.00	
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00
	records? If yes, see instructions.					
	COMPLETED BY COOT RELIGIOUS AND TEEDA HOOD TALO. ONLY (EVO		00017410)		1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS H	USPITALS)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases entered of the second of the seco	ed into during	this cost re	porting period?		24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cost	reporti ng		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (De	bt Service R	eserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see insti Has existing debt been replaced prior to its scheduled matu	ructions urity with new	debt? If yes	, see		30.00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see		31. 00
32. 00	Purchased Services Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		d through co	ntractual		32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, see instructions.		g to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an allf yes, see instructions.	rrangement with	provi der-ba	sed physicians?		34.00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 00
				Y/N	Date	
	LL 055			1. 00	2. 00	
36 00	Home Office Costs Were home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been pu	repared by the	home office?			37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			,		38. 00
39. 00	If line 36 is yes, did the provider render services to other			i.		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
		1. (00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TI NA		SEVERS		41. 00
42. 00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLO	С			42. 00
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

Heal th	Financial Systems	FRANCI SCAN	BEACON	I HOSPITAL				In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN: 1	5-0191	Peri		Worksheet S-2	2
							To	n 03/24/2021 12/31/2021	Part II Date/Time Pre 5/31/2022 2:3	
					3.00					
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the t	itle/position	MAN	IAGER						41. 00
	held by the cost report preparer in colum	ns 1, 2, and 3,								
	respecti vel y.									
42.00	Enter the employer/company name of the co	st report								42.00
	preparer.									
43.00	Enter the telephone number and email addr	ess of the cost	:							43.00
	report preparer in columns 1 and 2, respe	cti vel y.								

| Period: | Worksheet S-3 | From 03/24/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0191

						To 12/31/2021	Date/Time Pre 5/31/2022 2:3	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		8	2, 25	6 0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider							2. 00 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 SNI							6.00
7. 00	Total Adults and Peds. (exclude observation			8	2, 25	6 0.00		7. 00
7.00	beds) (see instructions)			O	2,23	0.00	Ĭ	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)			8	2, 25	6 0.00	0	14.00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	00.00						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		0			0	
27. 00 28. 00	Total (sum of lines 14-26)			8			0	27. 00
28.00	Observation Bed Days						0	28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Histruction)							31.00
32. 00	Labor & delivery days (see instructions)			0		0		32.00
32. 00	Total ancillary labor & delivery room			U	1			32. 00
JZ. UI	outpatient days (see instructions)							JZ. U1
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
	1		'		•	1	1	

Health Financial Systems FRANCISC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0191

| Peri od: | Worksheet S-3 | From 03/24/2021 | Part I | Date/Time Prepared: |

				'	0 12/31/2021	5/31/2022 2: 3	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	, p
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	omponent	I tro xviii	TI CI O XIX	Patients	& Residents	Payroll	
		6.00	7. 00	8.00	9, 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	115	1	256			1. 00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO I PF Subprovi der	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	115	1	256			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)	115	1	256	0.00	822. 60	14. 00
15.00	CAH vi si ts	0	0	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	822. 60	27. 00
28.00	Observation Bed Days		0	98			28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	O					33. 01

| Peri od: | Worksheet S-3 | From 03/24/2021 | Part I | Date/Time Prepared: |

					12/31/2021	5/31/2022 2:3	
		Full Time		Di sch	arges		
		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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	46	1	97	1. 00
	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		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0.00	0	46	1	97	14. 00
15. 00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	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						32. 01
00.5-	outpatient days (see instructions)			_			
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| Peri od: | Worksheet S-3 | From 03/24/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0191

					To	12/31/2021	Date/Time Prep 5/31/2022 2:38	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	Sal ari es	Paid Hours Related to	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
	PART II - WAGE DATA	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	2, 068, 685	o c	2, 068, 685	65, 809. 00	31. 43	1. 00
2.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		C	O	0	0.00	0.00	3. 00
4. 00	Physician-Part A - Administrative		C	o	0	0.00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C	0	1	0. 00 0. 00	1	1
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	O	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	C	0	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		C	C	О	0.00	0.00	7. 01
8.00	Home office and/or related organization personnel		C	o	0	0.00	0. 00	8. 00
9.00	SNF	44. 00	C	0	-	0.00	1	
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS				U	0.00	0.00	10.00
11. 00	Contract Labor: Direct Patient		C	0	0	0.00	0.00	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		C	C	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part		C	C	0	0.00	0.00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and wage-related costs		C	O	О	0.00	0. 00	14. 00
14. 01	Home office salaries		C	0	-	0.00	1	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C		0	0. 00 0. 00	1	1
	- Administrative							
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	C	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	C	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see instructions)		533, 361	С	533, 361			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		C	0	0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	O	0			21. 00
22. 00	Physician Part A - Administrative		C	C	0			22. 00
22. 01	Physician Part A - Teaching		C	0	1			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		C		0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		C	O	0			25. 00
25. 50	Home office wage-related		C	O	0			25. 50
25. 51	(core) Related organization wage-related (core)		C	o	0			25. 51
25. 52	, ,		C	O	0			25. 52

In Lieu of Form CMS-2552-10
Worksheet S-3
24/2021 Part II
31/2021 Date/Time Prepared:
5/31/2022 2:38 pm
Hours Average Hourly Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0191 Peri od: From 03/24/2021 To 12/31/2021

		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	0	0	0	0.00	0.00	26. 00
27.00	Administrative & General	5. 00	0	110, 109	110, 109	7, 748. 00	14. 21	27. 00
28. 00	Administrative & General under		0	0	0	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	0	0	0	0.00	0.00	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	0	0	0	0.00	0.00	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Li brary							
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00
				•				

| Peri od: | Worksheet S-3 | From 03/24/2021 | Part III | To 12/31/2021 | Date/Time Prepared:

					'	0 12/31/2021	5/31/2022 2:38	
		Worksheet A	Amount	Reclassi fi cati	Adjusted	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		2, 068, 685	0	2, 068, 685	65, 809. 00	31. 43	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		2, 068, 685	0	2, 068, 685	65, 809. 00	31. 43	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		0	0	0	0.00	0. 00	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		533, 361	0	533, 361	0.00	25. 78	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		2, 602, 046		2, 602, 046	i i		6. 00
7.00	Total overhead cost (see		0	110, 109	110, 109	7, 748. 00	14. 21	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 03/24/2021 Part IV

	To 12/31/2021	Date/Time Prep 5/31/2022 2:38	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	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)		
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)	533, 361	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
	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
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	0	17. 00
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	0	19. 00
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. (see instructions))	0	21. 00
	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	533, 361	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Pre 5/31/2022 2:3	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1 00	2 00	

			3/31/2022 2.3	o piii
	Cost Center Description	Contract Labor	Benefit Cost	
		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	533, 361	1.00
2.00	Hospi tal	0	533, 361	2. 00
3.00	Subprovi der - IPF			3. 00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swi ng Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			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	0	0	17. 00
18. 00	0ther	0	0	18. 00

OSPI T	Financial Systems FRANCISCAN BEACON TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0191	Peri od:	worksheet S-1		
			From 03/24/2021 To 12/31/2021	Date/Time Pre	narod	
			10 12/31/2021	5/31/2022 2: 3		
				1. 00		
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by line 202 colu	mn 8)	0. 304104	1. (
00	Net revenue from Medicaid			1	2.0	
00	Did you receive DSH or supplemental payments from Medicaid?				3.	
00	If line 3 is yes, does line 2 include all DSH and/or supplemen	cai d?		4.0		
00	If line 4 is no, then enter DSH and/or supplemental payments f Medicaid charges		0	5. (6. (
00	Medicaid cost (line 1 times line 6)			o o		
00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum of l	ines 2 and 5; if	0	8. (
	< zero then enter zero)	I ! \				
00	Children's Health Insurance Program (CHIP) (see instructions for Net revenue from stand-alone CHIP	or each rine)		0	9. (
0.00	Stand-alone CHIP charges			0		
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0	1	
2. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 minus line 9;	if < zero then	0	12. (
	enter zero) Other state or local government indigent care program (see ins	tructions for each lin	٥١		-	
3. 00	Net revenue from state or local indigent care program (Not inc			0	13.	
4. 00	Charges for patients covered under state or local indigent car	· · · · · · · · · · · · · · · · · · ·	,	0	1	
	10)					
5.00	State or local indigent care program cost (line 1 times line 1		ino 1E minuo lino	0	1	
5. 00	O Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)	IP and state/local ind	igent care program	ms (see		
7. 00	Private grants, donations, or endowment income restricted to f	unding charity care		0	17. (
3. 00	Government grants, appropriations or transfers for support of	9		0	18.	
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	l indigent care progra	ms (sum of lines	0	19. (
	O 12 and 10	Uni nsured	d Insured	Total (col. 1		
		pati ents		+ col . 2)		
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00		
0. 00	Charity care charges and uninsured discounts for the entire fa	cility	1 1	2	20.0	
	(see instructions)					
1. 00		unts (see	0 1	1	21. (
2. 00	<pre>instructions) Payments received from patients for amounts previously written</pre>	off as	0 0	0	22. (
2. 00	charity care	011 43			22.	
3. 00			0 1	1	23. (
				4.00		
1 00	Does the amount on line 20 column 2, include charges for patie	nt days beyond a Lengt	h of stay limit	1. 00 N	24. (
	imposed on patients covered by Medicaid or other indigent care	program?	•			
5. 00	If line 24 is yes, enter the charges for patient days beyond t stay limit	ne indigent care progr	am s rength or	0	25. (
5. 00	Total bad debt expense for the entire hospital complex (see in	structions)		6, 664	26.	
7. 00	Medicare reimbursable bad debts for the entire hospital comple			4, 332	27. (
7 01		see instructions)		6, 664		
7. 01	Non-Medicare bad debt expense (see instructions)			1 0	28. (
3. 00		nense (see instruction	e)	2 222	20 0	
	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see instruction	s)	2, 332 2, 333		

Heal th	Financial Systems	FRANCISCAN BEACO	N HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C)F EXPENSES	Provi der C	CN: 15-0191 P	eri od:	Worksheet A	
					rom 03/24/2021	D-+- /T: D	
					o 12/31/2021	Date/Time Pre 5/31/2022 2:3	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	о рііі
	cost center bescription	Jai ai i es	Other	+ col . 2)	ons (See A-6)	Trial Balance	
				+ (01. 2)	ons (see A-o)	(col. 3 +-	
		1 00	2.00	2.00	4.00	col . 4)	
	CENEDAL CEDIU CE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		4 440 (0)	1 110 101		1 110 (0)	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 112, 696	1, 112, 696	0	.,	1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUI P		0		0	0	2. 00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	533, 361			533, 361	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	1, 342, 851	1, 342, 851	110, 109	1, 452, 960	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0) C	0	0	6. 00
7.00	00700 OPERATION OF PLANT	0	490, 428	490, 428	0	490, 428	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	863	863	0	863	8. 00
9.00	00900 HOUSEKEEPI NG	o	711	711	0	711	9. 00
10.00	01000 DI ETARY	ol	2, 925	2, 925	0	2, 925	10.00
11. 00	01100 CAFETERI A	0	, 0		0	0	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		0	Ö	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON		0		0	Ö	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		0		i o		14. 00
15. 00	01500 PHARMACY		0				15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0				
16.00		١	0				16.00
17. 00	01700 SOCIAL SERVICE	0)	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 068, 685	7, 330	2, 076, 015	-2, 067, 829	8, 186	30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0	0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0) C	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	0	7, 285	7, 285	686, 596	693, 881	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	ol	0	ol c	0	0	56. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0		o o		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0			٥	59. 00
60. 00	06000 LABORATORY		620, 535	620, 535	0	620, 535	60.00
	1 1		020, 555	020, 555			
60. 01	06001 BLOOD LABORATORY	U	0			0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		U		0	0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	Ü		0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ü		0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	O	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) C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0) C	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	9, 312	9, 312	. 0	9, 312	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0) c	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	ol c	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	199, 874	199, 874		199, 874	73. 00
74. 00	07400 RENAL DIALYSIS		. , , , , , ,	1,,,,,,,	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	٥	0			0	75. 00
	07700 ALLOGENEIC STEM CELL ACQUISITION		0				
77.00	- '	UU	U	<u>'</u>	ıl O	0	77. 00
00 00	OUTPATIENT SERVICE COST CENTERS			J 0			00 00
90.00	09000 CLI NI C	0	1 100 570	1	0	0	90.00
91. 00	09100 EMERGENCY	0	1, 429, 570	1, 429, 570	1, 271, 124	2, 700, 694	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					<u> </u>	92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		2, 068, 685	5, 757, 741	7, 826, 426	0	7, 826, 426	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0) C	0		190. 00
191.00	19100 RESEARCH	0	0) C	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		0) c	0		192. 00
	19300 NONPALD WORKERS		0	0	0	0	193. 00
200.00	l l	2, 068, 685	5, 757, 741	7, 826, 426	0		
							-

Peri od: From 03/24/2021 To 12/31/2021 Date/Time Prepared: 5/31/2022 2:38 pm

				5/31/2022 2:3	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	_	I	T.	4
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	1, 112, 696		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	0	0		2.00
3.00	00300 OTHER CAP REL COSTS	0	522 2/1	l .	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0.043	533, 361		4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-9, 942	1, 443, 018		5.00
7. 00	00700 OPERATION OF PLANT	0	490, 428	l .	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	863		8. 00
9. 00	00900 HOUSEKEEPING	0	711		9. 00
10.00	01000 DI ETARY	0	2, 925		10.00
11. 00	01100 CAFETERI A	0	_,		11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	•	12. 00
13.00	01300 NURSING ADMINISTRATION	0	o c		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	O		14. 00
15.00	01500 PHARMACY	0	0		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		16. 00
17. 00	01700 SOCIAL SERVICE	0	C		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS	0	8, 186)	30.00
	ANCILLARY SERVICE COST CENTERS			.T	
50.00	05000 OPERATI NG ROOM	0		i e e e e e e e e e e e e e e e e e e e	50.00
51. 00	05100 RECOVERY ROOM	0	0	l control of the cont	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	•	52.00
53.00	05300 ANESTHESI OLOGY	0	402 991	l control of the cont	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	693, 881 0		54. 00 55. 00
56. 00	05600 RADI OLOGT - THERAPEUTT C	0			56.00
57. 00	05700 CT SCAN	0			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		l .	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		l .	59. 00
60.00	06000 LABORATORY	0	620, 535	l .	60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	l c		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65.00	06500 RESPI RATORY THERAPY	0	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, 312		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	·	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	·	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	100.074		72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	199, 874 0		73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)	0		i e e e e e e e e e e e e e e e e e e e	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		·	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0		<u>' </u>	77.00
90. 00	09000 CLINIC	0			90.00
91. 00	09100 EMERGENCY	-1, 343, 828	-	l .	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,	, ,		92.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 353, 770	6, 472, 656		118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		190. 00
	19100 RESEARCH	0	O		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	O		192. 00
	19300 NONPALD WORKERS	0	0		193. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-1, 353, 770	6, 472, 656)	200. 00

Heal th Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-0191 From 03/24/2021 To 12/31/2021 Date/Time Prepared:

					5/31/2022 2:	38 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	110, 109	0		1. 00
2.00	EMERGENCY	91.00	1, 271, 124	0		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	686, 596	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	856	0		4. 00
	TOTALS		2, 068, 685	0		
500.00	Grand Total: Increases		2, 068, 685	0		500.00

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0191 Period: From 03/24/2021 From 03/24/2021 Pata/Time Propagation

						То	Date/Time P 5/31/2022 2	
		Decreases					3/31/2022 2	Jo piii
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10.00			
	A - SALARY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	2, 068, 685		0 0)		1. 00
2.00		0.00	0		0 0)		2. 00
3.00		0.00	0		0 0)		3. 00
4.00		0.00	0		0 0)		4. 00
	TOTALS		2, 068, 685		0			
500.00	Grand Total: Decreases		2, 068, 685		0			500.00

				Ť	o 12/31/2021	Date/Time Pre 5/31/2022 2:3	
				Acqui si ti ons			
		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	T BALANCES					
1.00	Land	0	1, 514, 351	C	1, 514, 351	0	1. 00
2.00	Land Improvements	0	42, 865	C	42, 865	0	2. 00
3.00	Buildings and Fixtures	0	18, 535, 918	C	18, 535, 918	0	3. 00
4.00	Building Improvements	0	321, 825	C	321, 825	0	4. 00
5.00	Fi xed Equipment	0	3, 723, 493	C	3, 723, 493	0	5. 00
6.00	Movable Equipment	0	905, 250	C	905, 250	0	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	0	25, 043, 702	C	25, 043, 702	0	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	0	25, 043, 702	C	25, 043, 702	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	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 Equipment	3, 723, 493	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, 043, 702	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	25, 043, 702	O				10. 00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0191 Period: From 03/24/2021 To 12/31/2021 Part II Date/Time Prepare 5/31/2022 2: 38 pm SUMMARY OF CAPITAL Cost Center Description Depreciation Lease Interest Insurance (see instructions) instructions) 9.00 10.00 11.00 12.00 13.00	2-10
Cost Center Description Depreciation Depreciation Depreciation Lease Interest Insurance (see instructions) To 12/31/2021 Date/Time Prepare 5/31/2022 2: 38 pm SUMMARY OF CAPITAL Insurance (see instructions)	
SUMMARY OF CAPITAL Cost Center Description Depreciation Depreciation Lease Interest Insurance (see instructions)	od:
Cost Center Description Depreciation Lease Interest Insurance (see instructions) instructions)	
instructions) instructions)	
instructions) instructions)	
9.00 10.00 11.00 12.00 13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2	
1.00 CAP REL COSTS-BLDG & FIXT 1,112,696 0 0 0 1.	. 00
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.	2. 00
3.00 Total (sum of lines 1-2)	3. 00
SUMMARY OF CAPITAL	
Cost Center Description Other Total (1) (sum	
Capital-Relate of cols. 9	
d Costs (see through 14)	
i nstructi ons)	
14. 00 15. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2	
1. 00 CAP REL COSTS-BLDG & FIXT 0 1, 112, 696 1.	. 00
	2. 00
3.00 Total (sum of lines 1-2) 0 1,112,696 3.	3. 00

Health Financial Systems	FRANCISCAN BEA	ACON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 03/24/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/31/2022 2:3	pared:
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00 CAP REL COSTS-BLDG & FLXT	24, 138, 452		24, 138, 45		0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	905, 250		905, 25		0	2. 00
3.00 Total (sum of lines 1-2)	25, 043, 702		25, 043, 70			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)	2.00	40.00	
DADT III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	INTERS		ı	0 1 110 (0)	0	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	0			0 1, 112, 696	0	1. 00 2. 00
3.00 Total (sum of lines 1-2)	0			0 0 1, 112, 696	0	3.00
3.00 Total (Suil Of Titles 1-2)	U	VI CI	JMMARY OF CAPI		U	3.00
		30	DIVINIART OF CAPT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		1	1			
1.00 CAP REL COSTS-BLDG & FIXT	0	1		0	1, 112, 696	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	1		0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	"	0 0	1, 112, 696	3. 00

					7 12/31/2021	5/31/2022 2: 3	B pm
				Expense Classification on To/From Which the Amount is 1			
					•		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 0	1. 00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5.00	discounts (chapter 8) Refunds and rebates of	В	-4, 045	ADMINISTRATIVE & GENERAL	5. 00	О	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		O		0.00		7.00
8.00	21) 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	Provi der-based physician	A-8-2	-1, 343, 828		0.00	Ö	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			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		0		0. 00	0	16. 00
17.00	patients		0		0.00		17 00
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	О	19. 00
	books, etc.)		_			_	
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3	O	FITTST CAL THERAFT	00.00		24.00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	100	0		0.00		29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
31.00	pathology costs in excess of	A 3-3	0	STEEDIT I MINDEOUT	00.00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest OTHER INCOME	В	-5. 897	ADMINISTRATIVE & GENERAL	5. 00	<u> </u>	33. 00
	TOTAL TROOME	I 6	-5, 077	PROMINI STRAIT VE & OLIVEIAL	5.00	1 0	

Health Financial Systems		FRANCISCAN BEA	ACON HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0191	Peri od: From 03/24/2021	Worksheet A-8		
				To 12/31/2021	Date/Time Pre 5/31/2022 2:3		
			Expense Classification of	on Worksheet A			
			To/From Which the Amount i	s 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, 353, 770				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 12/31/202	Date/Time Pre 5/31/2022 2:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		EMERGENCY	1, 343, 828			0 211, 500	1	
2.00	0.00		0		-	0 0	•	
3.00	0.00		0		~	0 0	1	
4.00	0.00		0		0	0 C	0	
5. 00	0.00		0		0	0 0	0	0.00
6.00	0.00		0		0	0 0	0	
7. 00	0.00		0		0	0 0	0	7.00
8. 00	0.00		0		0	0	0	0.00
9. 00	0.00		0		0	0 0	0	9. 00
10.00	0.00		0		0	0 C	0	10. 00
200.00			1, 343, 828			0	0	
	Wkst. A Line #		Unadjusted RCE			Provi der	Physician Cost	
		Identifier	Limit		E Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1 00	1.00	2.00	8.00	9. 00	12. 00	13.00	14.00	4 00
1.00		EMERGENCY	0			0 0	0	
2. 00	0. 00		0	•	-	0 0	1	
3. 00	0.00	1	0		0	0	0	0.00
4.00	0. 00		0		0	0	0	
5. 00	0. 00		0		0	0	0	0.00
6.00	0.00		0		0	0	0	0.00
7. 00	0.00		0		O	0	0	7. 00
8. 00	0.00		0		0	0	0	8. 00
9. 00	0.00		0		0	0	0	7.00
10.00	0.00		0		0	0	0	
200.00		45.	0		0	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		I denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	+	
1. 00		EMERGENCY	15.00			0 1, 343, 828		1. 00
2. 00	0.00					0 1, 343, 626	1	2. 00
3. 00	0.00				-		1	3. 00
4. 00	0.00			1				4. 00
5. 00	0.00			·	0			5. 00
6. 00	0.00				0			6. 00
7. 00	0.00							7. 00
	0.00				0			4
8. 00 9. 00	0.00		0		0			8. 00 9. 00
	0.00		0		~			10.00
10.00	0.00				~	-1		
200.00	I	I	1	l '	U _I	0 1, 343, 828	יו	200. 00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0191 Peri od: Worksheet B From 03/24/2021 Part I Date/Time Prepared: 12/31/2021 5/31/2022 2:38 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 112, 696 1, 112, 696 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 0 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 533, 361 0 533, 361 4.00 00500 ADMINISTRATIVE & GENERAL 0 5 00 54, 778 28, 389 1, 526, 185 5 00 1, 443, 018 0 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 490, 428 126, 031 616, 459 7.00 0 8.00 00800 LAUNDRY & LINEN SERVICE 863 20, 481 0 21, 344 8.00 0 00900 HOUSEKEEPI NG 5, 453 9 00 711 4, 742 9 00 10.00 01000 DI ETARY 2,925 17, 210 0 0 20, 135 10.00 01100 CAFETERI A 0 o 11.00 0 0 11.00 0 01200 MAINTENANCE OF PERSONNEL 0 12.00 12.00 0 0 0 01300 NURSING ADMINISTRATION 0 0 13.00 Ω 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 14.00 0 01500 PHARMACY 0 0 15.00 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16, 00 16,00 0 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 186 348, 006 0 221 356, 413 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 Λ 50.00 0 05100 RECOVERY ROOM 0 0 0 51.00 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 693, 881 243, 764 0 177, 022 1, 114, 667 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 C 0 0 0 57.00 05700 CT SCAN 0 C Ω 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 0 59.00 06000 LABORATORY 620, 535 0 638, 236 60.00 17, 701 60.00 0 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 62.00 0 0 0 06300 BLOOD STORING, PROCESSING & TRANS 0 63.00 Ω 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 06600 PHYSI CAL THERAPY 0 66 00 Ω 0 66 00 06700 OCCUPATIONAL THERAPY 0 0 67.00 C 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 9, 312 0 0 22,066 69.00 12, 754 07000 ELECTROENCEPHALOGRAPHY 0 70 00 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 C 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 199,874 9, 280 0 209, 154 73.00 0 07400 RENAL DIALYSIS 74 00 0 C 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 C 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 0 91.00 09100 EMERGENCY 1, 356, 866 257, 949 0 327, 729 1, 942, 544 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 6, 472, 656 1, 112, 696 0 533, 361 6, 472, 656 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 01191.00 191. 00 19100 RESEARCH 0 C 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 0

0

6, 472, 656

1, 112, 696

0

0

0

0

533, 361

0 193.00

0 200, 00

0 201.00

6, 472, 656 202. 00

193. 00 19300 NONPALD WORKERS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 03/24/2021	Part
To 12/31/2021	Date/Time Prepared:
5/31/2022 2:38 pm	

					12/31/2021	5/31/2022 2: 3	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	'	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVI CE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 526, 185					5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0				6. 00
7. 00	00700 OPERATION OF PLANT	190, 202	0	806, 661			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	6, 585	0	17, 728	45, 657		8. 00
9.00	00900 HOUSEKEEPI NG	1, 682	0	4, 105	0		9. 00
10.00	01000 DI ETARY	6, 212	0	14, 898	0	_	1
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100.000		204 040	00.000	4 045	00.00
30. 00	03000 ADULTS & PEDI ATRI CS	109, 968	0	301, 242	22, 828	4, 315	30.00
FO 00	ANCI LLARY SERVI CE COST CENTERS		0	ı o	0		F0 00
50.00	05000 OPERATING ROOM	0	U	0	0	-	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	O5200 DELI VERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	242 010	U	0	0	0	53.00
54.00	05500 RADI OLOGY - DI AGNOSTI C	343, 919	0	211, 007	0	3, 022	54.00
55. 00		0	0	0	0	0	55.00
56. 00 57. 00	05600	0	0	0	0	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
59. 00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	196, 921	0	15, 322	0	219	60.00
60. 00	06001 BLOOD LABORATORY	170, 721		15, 322	0		60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			U	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	Ö	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	Ö	0	0	64. 00
65. 00	06500 RESPIRATORY 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	Ö	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	Ö	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 808	0	11, 040	0	158	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0,000	Ö	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	Ö	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	0	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	64, 532	Ö	8, 033	0	115	1
74. 00	07400 RENAL DI ALYSI S	0	Ö	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	Ö	ō	0	0	75. 00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	Ö		0		1
	OUTPATIENT SERVICE COST CENTERS	_		-1	-	-	1
90.00	09000 CLI NI C	0	O	0	0	0	90.00
	09100 EMERGENCY	599, 356		1	22, 829		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_		, -		92.00
	SPECIAL PURPOSE COST CENTERS	•		,			1
118.00		1, 526, 185	C	806, 661	45, 657	11, 240	118. 00
	NONREI MBURSABLE COST CENTERS	,				,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 00
	19100 RESEARCH	0	O	1	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	O	1	0		192. 00
	19300 NONPALD WORKERS	0	O	0	0		193. 00
200.00		1					200. 00
201.00	Negative Cost Centers	0	O	o	0	0	201. 00
202.00		1, 526, 185	O	806, 661	45, 657	11, 240	202. 00
		•					•

						5/31/2022 2: 3	8 pm
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	1 1						1
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	41, 458					10.00
11. 00	01100 CAFETERI A	0					11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0					12. 00
	1 1	0					1
	01300 NURSI NG ADMINI STRATI ON	0			0		13.00
	01400 CENTRAL SERVICES & SUPPLY	0	(0	0	
	01500 PHARMACY	0	(0	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	() c	0	0	16. 00
17.00	01700 SOCIAL SERVICE	0	(0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			*			1
30.00	03000 ADULTS & PEDIATRICS	41, 458			0	0	30.00
00.00	ANCILLARY SERVICE COST CENTERS	11, 100		٥,	· · · · · · · · · · · · · · · · · · ·		30.00
50. 00	05000 OPERATING ROOM	O			0	0	50.00
	1	l l		1			1
	05100 RECOVERY ROOM	0		0		· -	
	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	
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	55. 00
56.00	05600 RADI 0I S0T0PE	0		ol d	0	0	1
57. 00	05700 CT SCAN	0			0	l o	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)					0	1
		0				1	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	•	0	0	0	
60.00	06000 LABORATORY	0	(0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	(O C	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	(ol c	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	ol		ol d	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	ام			0	أ أ	64. 00
65. 00	06500 RESPIRATORY THERAPY					١	65. 00
	1 1						1
	06600 PHYSI CAL THERAPY	U			0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	•	o	0	0	
	06800 SPEECH PATHOLOGY	0	(0	0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	(O C	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(o	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	ol	(ol c	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	ام			0	0	73. 00
74. 00	1 1					0	1
	07400 RENAL DIALYSIS	0				· -	
75. 00	07500 ASC (NON-DISTINCT PART)	0	•)	0	0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		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	0	(0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						1
118. 00		41, 458			0		118. 00
110.00		41, 430		<u>J</u>	1 0	0	1116.00
	NONREI MBURSABLE COST CENTERS			-	_	_	4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00
	19100 RESEARCH	0	(O C	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	(0	0		192. 00
193.00	19300 NONPALD WORKERS	ol	(o) c	0	0	193. 00
200.00							200. 00
201. 00	1 1	n	(ol lo	n	n	201. 00
202. 00		41, 458			Ö		202. 00
202.00	1 1.577.E (36 1171.03 110 till 04gir 201)	1 41,430	,	٠,		ı	1-02.00

| Period: | Worksheet B | From 03/24/2021 | Part | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0191

				T	12/31/2021		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	5/31/2022 2:3	8 pm
	0001 00.1101 20001 pt. 0.1		RECORDS &	0001712 02117102		Residents Cost	
			LI BRARY			& Post	
						Stepdown Adjustments	
		15. 00	16. 00	17. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS			T			
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00 2. 00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT						7. 00
9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	O					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	(16. 00
17. 00	01700 SOCIAL SERVICE	0	(0			17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	ol	(0	836, 224	0	30. 00
30. 00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>	030, 224		30.00
50.00	05000 OPERATING ROOM	0	(0	_	50. 00
51.00	05100 RECOVERY ROOM	0	(0	0	-	51.00
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY		(0 0	0	0 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		(ol ö	1, 672, 615	-	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	(0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	(0	0	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0 0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		(0	0	59. 00
60.00	06000 LABORATORY	o	Č	o o	850, 698	_	60.00
60. 01	06001 BLOOD LABORATORY	0	(0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.		(0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY		(ol ö	0	Ö	64. 00
65.00	06500 RESPIRATORY THERAPY	O	(0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	(0	0	0	66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY	0	(0	0	0 0	67. 00 68. 00
69. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY		(0 0	40, 072	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	(o o	0	Ö	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0	0	-	72.00
	O7300 DRUGS CHARGED TO PATIENTS O7400 RENAL DIALYSIS	0	(281, 834 0	0	
	07500 ASC (NON-DISTINCT PART)		(1	0	0	75. 00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	(0	0		77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C 09100 EMERGENCY	0	(0 0	0 2, 791, 213		90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	٩)	2, 771, 213	0	92.00
	SPECIAL PURPOSE COST CENTERS	1		1			
118.00		0	(0	6, 472, 656	0	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	(0	0	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		(•	0		190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	o	Ć	o o	0	0	192. 00
	19300 NONPALD WORKERS	0	(0	0		193. 00
200.00	1 1		,		0		200. 00 201. 00
201. 00 202. 00	1 1 0		(0 0	6, 472, 656		201.00 202.00
	, (oog. 201)	, 9			-, ., 2, 300	Ĭ	

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

| Peri od: | Worksheet B | From 03/24/2021 | Part | To 12/31/2021 | Date/Time Prepared: 5/31/2022 2:38 pm

			5/31/2022 2:	38 pm
	Cost Center Description	Total		
		26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAINTENANCE & REPAIRS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL			12. 00
13. 00	1			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS			- 17.00
20 00	03000 ADULTS & PEDIATRICS	836, 224		30.00
30.00	ANCI LLARY SERVICE COST CENTERS	030, 224		30.00
50. 00		O		50.00
51. 00				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		52. 00
53. 00		0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 672, 615		54. 00
55. 00	1	0		55. 00
56. 00	05600 RADI OI SOTOPE	0		56. 00
57. 00	05700 CT SCAN	0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		59. 00
60.00	06000 LABORATORY	850, 698		60.00
60. 01	06001 BLOOD LABORATORY	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		63.00
64.00	06400 I NTRAVENOUS THERAPY	0		64. 00
65.00	06500 RESPIRATORY THERAPY	0		65.00
66.00	06600 PHYSI CAL THERAPY	0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o		67. 00
68.00	06800 SPEECH PATHOLOGY	o		68. 00
69.00	06900 ELECTROCARDI OLOGY	40, 072		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70.00
71. 00		0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS			72. 00
73. 00		281, 834		73. 00
74. 00	07400 RENAL DIALYSIS	0		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)			75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION			77. 00
, , . 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		⊢ ,,,,,,,
90 00	09000 CLINIC	O		90.00
	09100 EMERGENCY	2, 791, 213		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 191, 213		91.00
92.00				92.00
110 00	SPECIAL PURPOSE COST CENTERS	4 470 454		110 00
118.00	9 /	6, 472, 656		118. 00
100.00	NONREI MBURSABLE COST CENTERS			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19100 RESEARCH	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
	19300 NONPALD WORKERS	0		193. 00
200.00		0		200. 00
201.00	Negative Cost Centers	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	6, 472, 656		202. 00
		·		

| Peri od: | Worksheet B | From 03/24/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0191

				To	12/31/2021	Date/Time Pre 5/31/2022 2:3	
			CAPI TAL REI	LATED COSTS		3/31/2022 2.3	o pili
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	U	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	54, 778	0	54, 778	l	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	0	126, 031	0	126, 031	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	0	20, 481 4, 742	1	20, 481 4, 742		9.00
10. 00	01000 DI ETARY	0	17, 210		17, 210	l e	10.00
11. 00	01100 CAFETERI A	0	0		0	Ö	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	Ö	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	348, 006	0	348, 006	0	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	0	340,000	0	340, 000	0	30.00
50.00	05000 OPERATING 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	0	243, 764		243, 764	0	54.00
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	05600	0	0	0	0	0	56. 00 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	Ö	0	0	59. 00
60.00	06000 LABORATORY	0	17, 701	Ö	17, 701	0	60.00
60. 01	06001 BLOOD 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 06500 RESPI RATORY THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0 0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ö	Ö	0	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	12, 754	0	12, 754	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	9, 280	1	9, 280	0	1
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	74. 00 75. 00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77. 00
77.00	OUTPATIENT SERVICE COST CENTERS						77.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	257, 949	0	257, 949	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
440.00	SPECIAL PURPOSE COST CENTERS	1		1			
118. 00		0	1, 112, 696	0	1, 112, 696	0	118. 00
190 00	NONREIMBURSABLE COST CENTERS 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	O	0	0	190. 00
	19000 GIFT, PLOWER, COFFEE SHOP & CANTEEN			0	0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES		l		0		192. 00
	19300 NONPALD WORKERS	0	o	o	0		193. 00
200.00					0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	1, 112, 696	0	1, 112, 696	0	202. 00

| Peri od: | Worksheet B | From 03/24/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | P Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0191

					To	12/31/2021	Date/Time Pre 5/31/2022 2:3	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE	&	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	o pili
	oost conten boscii pti on	& GENERAL	REPAI RS	۱ "	PLANT	LINEN SERVICE	HOUSEREEFFING	
		5. 00	6.00		7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FLXT							1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP							2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	54, 778						5. 00
6.00	00600 MAI NTENANCE & REPAI RS	(027		0	122 050			6.00
7.00	00700 OPERATION OF PLANT	6, 827		0	132, 858	22 / 27		7.00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	236		0	2, 920	23, 637 0	5, 478	8. 00 9. 00
10. 00	01000 DI ETARY	223			676 2, 454	0	104	10.00
11. 00	01100 CAFETERI A	223			2, 434	0	0	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL				0	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON			0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			0	0	0	0	14. 00
15. 00	01500 PHARMACY	0		0	0	Ö	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0		0	0	Ö	0	16. 00
17. 00	01700 SOCIAL SERVICE	0		0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	'	<u>'</u>					
30.00	03000 ADULTS & PEDIATRICS	3, 947		0	49, 615	11, 818	2, 102	30. 00
	ANCILLARY SERVICE COST CENTERS							
50.00	O5000 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	12, 344		0	34, 753	0	1, 473	54. 00
55. 00	O5500 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 59. 00	O5800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	0	58. 00 59. 00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	7, 068			2, 524	0	107	60.00
60. 00	06001 BLOOD LABORATORY	7,000			2, 524	0	0	60. 00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			٩	O	O	O	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	Ö	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0	0	Ö	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0		o	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		0	0	0	0	66. 00
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	244		0	1, 818	0	77	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 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 316		0	1, 323	0	56	73. 00
74. 00	07400 RENAL DI ALYSI S	0		0	0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0		0	0	0	0	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		U	0	0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS		I		0	ما	0	00.00
	09000 CLI NI C	0		0	0	11 010	1 550	
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	21, 513		0	36, 775	11, 819	1, 559	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS							92.00
118. 00		54, 778		o	132, 858	23, 637	5 478	118. 00
110.00	NONREI MBURSABLE COST CENTERS	34,770	l	기	132, 030	25, 037	5, 470	1.10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		ol	0	0	n	190. 00
	19100 RESEARCH	0		0	0	ő		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		0	0	ol		192. 00
	19300 NONPAI D WORKERS	0		0	0	o		193. 00
200.00								200. 00
201.00		0		0	0	o	0	201. 00
202.00		54, 778		0	132, 858	23, 637		202. 00
	• •				•			

Provider CCN: 15-0191

| Peri od: | Worksheet B | From 03/24/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | P

				1	To 12/31/2021	Date/Time Pre 5/31/2022 2:3	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	, p
				PERSONNEL	ADMI NI STRATI ON	SERVICES &	
		10.00	11. 00	12.00	13.00	SUPPLY 14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					ı	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					ı	4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL					ı	5. 00
6.00	00600 MAI NTENANCE & REPAI RS					ı	6.00
7.00	00700 OPERATION OF PLANT					ı	7. 00
8. 00 9. 00	O0800					ı	8. 00 9. 00
10. 00	01000 DI ETARY	19, 991				ı	10.00
11. 00	01100 CAFETERI A	17, 771	(ı	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	o	(ol (ı	12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	o	(ol ol	ı	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	(o	0	14. 00
15.00	01500 PHARMACY	0	(o o	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	(0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	(0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00	03000 ADULTS & PEDI ATRI CS	19, 991	(0	0	30.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	ol	(ol lo	0	50.00
51. 00	05100 RECOVERY ROOM	0	(1		0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	
53. 00	05300 ANESTHESI OLOGY	o	(ol ol	Ö	
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	Ć		o	0	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(o o	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	(o o	0	56. 00
57.00	05700 CT SCAN	0	(0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	(0	0	59. 00
60.00	06000 LABORATORY	0	(0	0	
60. 01	06001 BLOOD LABORATORY	0	(이	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0	
64. 00	06400 I NTRAVENOUS THERAPY	0	(0	1
65. 00	06500 RESPIRATORY THERAPY	0	(. 0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	(0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	(ol ol	Ö	1
68. 00	06800 SPEECH PATHOLOGY	O	Ć		o	0	1
69.00	06900 ELECTROCARDI OLOGY	0	(ol ol	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(o o	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	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	(0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	(0	0	
	07500 ASC (NON-DISTINCT PART)	0	(0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	(0	0	77. 00
90 00	09000 CLINIC	O	(ol ol	0	90. 00
	09100 EMERGENCY	o	(1	ol ol	Ö	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					1	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	,	19, 991	() (0	0	118. 00
	NONREI MBURSABLE COST CENTERS			1	1		4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(0		190. 00
	19100 RESEARCH	0	(191. 00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	(192. 00 193. 00
200.00		٩	(1	1 4	U	200.00
200.00		0	() (ار ار	n	200.00
202.00		19, 991	(ol d			202. 00
30	, , , , , , , , , , , , , , , , , , ,	,.,,			, 91	· ·	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B
Part II
Date/Time Prepared:
5/31/2022 2:38 pm
Intern & Provider CCN: 15-0191 Peri od: From 03/24/2021 To 12/31/2021 Cost Center Description PHARMACY MEDI CAL SOCIAL SERVICE Subtotal

	cost center bescription	THANNACT	RECORDS & LI BRARY	SOUTHE SERVICE	Subtotal	Resi dents Cost & Post Stepdown Adjustments	
		15. 00	16. 00	17. 00	24. 00	25. 00	
1 00	GENERAL SERVICE COST CENTERS					ı	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERIA						11. 00
12.00	1						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					•	13. 00 14. 00
15. 00	1	0					15. 00
16. 00			(16. 00
	01700 SOCIAL SERVICE	l ol	C	o			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	C	0	435, 479	0	30. 00
	ANCILLARY SERVICE COST CENTERS					1	
50. 00		0	C	0	0	0	
51. 00	1	0	C	0	0	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	C		0	0	52. 00 53. 00
54. 00	1	0	C		292, 334		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C				272, 334	0	55. 00
56. 00	05600 RADI OI SOTOPE	l öl	C		0	o o	56. 00
57. 00	1 1	o	C	o	0	ō	57. 00
58.00	1 1	o	C	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	C	0	0	0	59. 00
60.00	06000 LABORATORY	0	C	0	27, 400	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	C	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	C	0	0	0	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0			0	0	63. 00 64. 00
65. 00	1				0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	ol ol	C		0	o o	66.00
67. 00	1	o	C	o	0	ō	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	C	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	C	0	14, 893	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	70. 00
71. 00	1	0	C	0	0	0	
72. 00	1	0	C	0	10.075	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0			12, 975	0	73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)	0			0	0	1
	07700 ALLOGENEIC STEM CELL ACQUISITION	o	C		0	_	
,,,,	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>			77.00
90.00	09000 CLI NI C	0	C	0	0	0	90. 00
	09100 EMERGENCY	0	C	0	329, 615	0	
92. 00						0	92. 00
110 00	SPECIAL PURPOSE COST CENTERS	O	C		1 112 (0)	1 0	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	l ol		0	1, 112, 696	0	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	(0	0	n	190. 00
	19100 RESEARCH	l ől	C	ol ől	0	l .	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	C	o o	0	0	192. 00
	19300 NONPALD WORKERS	o	C	0	0		193. 00
200.00					0		200. 00
201.00		0	C		0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	이	C	0	1, 112, 696	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FRANCISCAN BEACON HOSPITAL Provider CCN: 15-0191

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 03/24/2021	Part II
To 12/31/2021	Date/Time Prepared:
5/31/2022 2:38 pm	

			5/31/2022 2	
	Cost Center Description	Total	, , , , , , , , , , , , , , , , , , , ,	
	· · · · · · · · · · · · · · · · · · ·	26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6. 00	00600 MAI NTENANCE & REPAI RS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10. 00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL			12.00
13. 00	01300 NURSING ADMINISTRATION			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			•
				14.00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY			16.00
17. 00	01700 SOCIAL SERVICE			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	105 170		
30. 00	03000 ADULTS & PEDI ATRI CS	435, 479		30.00
	ANCILLARY SERVICE COST CENTERS			
50. 00	05000 OPERATING ROOM	0		50. 00
51. 00	05100 RECOVERY ROOM	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	292, 334		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
56.00	05600 RADI OI SOTOPE	0		56.00
57.00	05700 CT SCAN	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		59. 00
60.00	06000 LABORATORY	27, 400		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	o		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o		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	o o		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	o o		67. 00
68. 00	06800 SPEECH PATHOLOGY			68. 00
69. 00	06900 ELECTROCARDI OLOGY	14, 893		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	14, 075		70.00
71. 00		0		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS			71. 00 72. 00
72.00		12, 975		•
	07300 DRUGS CHARGED TO PATIENTS	12, 9/5		73.00
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		77. 00
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLINIC	0		90.00
91. 00	09100 EMERGENCY	329, 615		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	SPECIAL PURPOSE COST CENTERS			
118.00		1, 112, 696		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19100 RESEARCH	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
193.00	19300 NONPALD WORKERS	o		193. 00
200.00		o		200. 00
201.00		ا		201. 00
202.00		1, 112, 696		202. 00
30	(3.2 (3.2 (3.2 (3.2 (3.2 (3.2 (3.2 (3.2			1

					1	o 12/31/2021	Date/lime Pre 5/31/2022 2:3	
			CAPITAL REI	LATED COSTS			070172022 2.0	
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
			(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
					(GROSS SALARI ES)			
			1.00	2.00	4. 00	5A	5. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT	27, 219	1				1.0
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	0				2. 0 4. 0
5. 00	1	ADMINISTRATIVE & GENERAL	1, 340		2, 068, 685 110, 109		4, 946, 471	5.0
5. 00	1	MAINTENANCE & REPAIRS	0	o o	0		0	6. 0
7. 00	00700	OPERATION OF PLANT	3, 083	0	0	0	616, 459	7.0
3. 00		LAUNDRY & LINEN SERVICE	501	0	0	_	21, 344	8. 0
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	116 421	0	0		5, 453 20, 135	
1. 00	1	CAFETERIA	421	0		_	20, 135	11.0
2. 00	1	MAINTENANCE OF PERSONNEL	0	Ö	Ö	Ö	Ö	12.0
3. 00		NURSING ADMINISTRATION	0	0	0	0	0	13. C
4. 00	1	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.0
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	0	0		0	15. 0 16. 0
	1	SOCIAL SERVICE	0	0				17. 0
7. 00		I ENT ROUTI NE SERVI CE COST CENTERS						17.0
80. 00	03000	ADULTS & PEDI ATRI CS	8, 513	0	856	0	356, 413	30.0
		LARY SERVICE COST CENTERS	_		_	_		
0.00	1	OPERATING ROOM	0	0			l	50.0
2. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	0	0		0	51. C
3. 00	1	ANESTHESI OLOGY	0	0	Ö		Ö	53.0
4. 00	1	RADI OLOGY-DI AGNOSTI C	5, 963	0	686, 596	0	1, 114, 667	54. 0
5. 00		RADI OLOGY-THERAPEUTI C	0	0	0		0	55. (
6. 00	1	RADI OI SOTOPE	0	0	0	0	0	56. (
7. 00 8. 00	1	CT SCAN	0	0	0	0	0	57. 0 58. 0
9. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	0		_		59. (
0. 00	1	LABORATORY	433	Ö	Ö	0	638, 236	60.0
0. 01	06001	BLOOD LABORATORY	0	0	0	0	0	60.0
1. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_	_	0	_	61.0
2.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		0	62.0
3. 00 4. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0			0	63.0
5. 00		RESPI RATORY THERAPY	0	0	Ö	_	Ö	65.0
6. 00		PHYSI CAL THERAPY	0	0	0	0	0	66. (
7. 00	1	OCCUPATIONAL THERAPY	0	0	0	0	0	67.0
8. 00		SPEECH PATHOLOGY	0	0	0	0	0	68.0
9. 00 0. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	312	0		0	22, 066 0	
	1	MEDICAL SUPPLIES CHARGED TO PATIENTS		o o			Ö	
		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. (
3. 00		DRUGS CHARGED TO PATIENTS	227	0	0	0	209, 154	73. 0
		RENAL DIALYSIS	0	0	0	_	0	
		ASC (NON-DISTINCT PART) ALLOGENEIC STEM CELL ACQUISITION	0	0	_			1
7.00		TIENT SERVICE COST CENTERS				0		//.
	09000	CLI NI C	0	0	0	0	0	90. (
		EMERGENCY	6, 310	0	1, 271, 124	0	1, 942, 544	
2. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92.0
18. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	27, 219	0	2, 068, 685	-1, 526, 185	4, 946, 471	110 (
16.00		IMBURSABLE COST CENTERS	21,219	0	2,000,000	-1, 520, 165	4, 940, 471	1110. (
90. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. (
		RESEARCH	0	0	0	0	0	191. (
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. (
		NONPAID WORKERS	0	0	0	0	0	193. (
00. 00 01. 00	1	Cross Foot Adjustments Negative Cost Centers						200. (201. (
01. 00 02. 00	1	Cost to be allocated (per Wkst. B,	1, 112, 696	0	533, 361		1, 526, 185	1
00		Part I)	.,.,2,370]	230, 501		., 525, 155	\
03.00	1	Unit cost multiplier (Wkst. B, Part I)	40. 879386	0. 000000	0. 257826		0. 308540	
04.00)	Cost to be allocated (per Wkst. B,			0		54, 778	204. 0
	1	Part II) Unit cost multiplier (Wkst. B, Part			0. 000000		0. 011074	205 (
05. 00	١ ا							

Heal th Finar	ncial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CO		Peri od:	Worksheet B-1	
					From 03/24/2021 To 12/31/2021		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1. 00	2. 00	4.00	5A	5. 00	
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Provider CCN: 15-0191

Peri od: From 03/24/2021 To 12/31/2021 Date/Time Prepared:

					12/31/2021	5/31/2022 2: 3	
	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)			
		6. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	25, 879					6.00
7. 00	00700 OPERATION OF PLANT	3, 083	22, 796				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	501	501	100			8. 00
9.00	00900 HOUSEKEEPI NG	116	116	0	22, 179		9. 00
10.00	01000 DI ETARY	421	421	0	421	100	10.00
	01100 CAFETERI A	0	0	0	0	0	
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0	0	0	0	12. 00
	01400 CENTRAL SERVICES & SUPPLY	0			0		1
	01500 PHARMACY	0	0	0	0	0	1
	01600 MEDICAL RECORDS & LIBRARY	0	0	ō	0	Ö	1
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00	03000 ADULTS & PEDIATRICS	8, 513	8, 513	50	8, 513	100	30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	0	0	0	50.00
	05100 RECOVERY ROOM	0			0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	o o	0	0	
53.00	05300 ANESTHESI OLOGY	0	O	o	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 963	5, 963	0	5, 963	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
	05600 RADI OI SOTOPE	0	0	0	0	0	
	05700 CT SCAN	0	0	0	0	0	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	1 0		0	0	58. 00 59. 00
	06000 LABORATORY	433	433		433	1	1
	06001 BLOOD LABORATORY	0	0		0	Ö	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	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	
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	0	0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY	0	Ö		0	Ö	1
69.00	06900 ELECTROCARDI OLOGY	312	312	0	312	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	227	227	0	227 0	0	
	07500 ASC (NON-DISTINCT PART)	0	-		0		
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	l		0	l	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0		_			
	09100 EMERGENCY	6, 310	6, 310	50	6, 310	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118. 00		25, 879	22, 796	100	22, 179	100	118. 00
	NONREI MBURSABLE COST CENTERS	20,0,,		1.00	22,	100	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	1	_	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	· -		0		192. 00
	19300 NONPAI D WORKERS	0	0	0	0	0	193. 00
200. 00 201. 00							200. 00
202.00		0	806, 661	45, 657	11, 240	41 458	202.00
202.00	Part I)		000,001	10,007	1.7210	11, 100	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	35. 386077	456. 570000	0. 506786	414. 580000	203. 00
204.00		0	132, 858	23, 637	5, 478	19, 991	204. 00
205.00	Part II)	0.000000	E 020120	224 270000	0.244000	100 010000	205 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	5. 828128	236. 370000	0. 246990	199. 910000	205.00
206.00	l ,						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	i αιτο ττι απα τν <i>)</i>	<u> </u>	I	1	l 	I	1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0191 Peri od: Worksheet B-1 From 03/24/2021 12/31/2021 Date/Time Prepared: 5/31/2022 2:38 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL (MEALS SERVED) ADMI NI STRATI ON SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NURS HOUSED) (COSTED REQUIS.) HRS.) 11.00 12.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14 00 14 00 15.00 01500 PHARMACY 0 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 0 0 16.00 01700 SOCIAL SERVICE 17 00 O 0 0 17 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 n O 0 n 50 00 0 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 00000000 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 Ω 0 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05600 RADI OI SOTOPE 0 56.00 0 56.00 05700 CT SCAN 0 57.00 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 Ω 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 06000 LABORATORY 60.00 60.00 0 06001 BLOOD LABORATORY 0 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0000000000000 0 0 0 0 0 0 0 0 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 0 0 64.00 0 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 0 68.00 Λ 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07400 RENAL DIALYSIS 0 0 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 0 75 00 C 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 90.00 0 0 0 0 09100 EMERGENCY 91.00 0 C 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 118 00 118 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192 00 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 0 202. 00 202.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 0.000000 203.00 203.00 204.00 Cost to be allocated (per Wkst. B, 0 204.00 Part II) 0.000000 205.00 205.00 0.000000 0 000000 0.000000 0.000000 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				rom 03/24/2021 o 12/31/2021	Date/Time Pre 5/31/2022 2:3	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)	PERSONNEL	ADMI NI STRATI ON	SERVICES &	(COSTED	
		(NUMBER		SUPPLY	REQUIS.)	
		HOUSED)	(DIRECT NURS.	(COSTED		
			HRS.)	REQUIS.)		
	11.00	12.00	13. 00	14.00	15. 00	
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)		1				1

Health FinancialSystemsFRANCISCAN BEACON HOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 15-0191Period:Worksheet B-1

From 03/24/2021 12/31/2021 Date/Time Prepared: 5/31/2022 2:38 pm Cost Center Description MEDI CAL SOCIAL SERVICE RECORDS & LI BRARY (TIME SPENT) (TIME SPENT) 17.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 0 50.00 05100 RECOVERY ROOM 0 51 00 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000 0 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 0 58 00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 0 60.00 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 0 62.00 000000000000000 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 91.00 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Ω 202 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Health Financial Systems	FRANCISCAN BEA	ACON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0191			pared: 8 pm
		Title	XVIII	Hospi tal	PPS	•
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Total Cost Costs Cost	
(from Wkst. B, Adj. Disallowance Part I, col.	
(from Wkst. B, Adj. Disallowance Part I, col.	
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 836, 224 0 836, 224 3	0.00
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0 0 50	0.00
51. 00 05100 RECOVERY ROOM 0 0 0 5 5	1. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 5	2. 00
53. 00 05300 ANESTHESI OLOGY 0 0 0 5	3. 00
	4. 00
	5. 00
	6. 00
	7. 00
	8. 00
	9. 00
	0. 00
	0. 01
	1. 00
	2. 00
	3. 00
	4. 00
	5. 00
	6. 00
	7. 00
	8. 00
	9. 00
	0. 00
	1. 00
	2. 00
	3. 00
74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 0 0 0 74.00 0 0 0 0 0 74.00 0 0 0 0 0 0 0 0 0	4. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 7.	5. 00
77.00 OT7700 ALLOGENEIC STEM CELL ACQUISITION O O O O O	7. 00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0 0 90	0.00
91. 00 09100 EMERGENCY 2, 791, 213 2, 791, 213 0 2, 791, 213 9	1. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 231, 497 231, 497 231, 497 231, 497	2.00
200.00 Subtotal (see instructions) 6,704,153 0 6,704,153 0 6,704,153	0.00
201.00 Less Observation Beds 231,497 231,497 231,497 231,497	
202.00 Total (see instructions) 6,472,656 0 6,472,656 0 6,472,656 20	2. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/31/2022 2:38 pm
	T' 11 \0.011	11 1 1	DDC

				-	To 12/31/2021	Date/Time Pre 5/31/2022 2:3	
			Title	XVIII	Hospi tal PPS		
	·		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	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	534, 273		534, 27	3		30.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0	0		0. 000000	0. 000000	
	5100 RECOVERY ROOM	0	0		0. 000000	0. 000000	
	5200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	1
	5300 ANESTHESI OLOGY	0	0	,	0. 000000	0. 000000	
	5400 RADI OLOGY-DI AGNOSTI C	194, 464	8, 032, 661	8, 227, 12		0. 000000	
	5500 RADI OLOGY-THERAPEUTI C	0	0		0. 000000	0. 000000	
	5600 RADI OI SOTOPE	0	0		0. 000000	0. 000000	1
	5700 CT SCAN	0	0		0. 000000	0. 000000	1
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000	0. 000000	
	5900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	
	6000 LABORATORY	360, 098	3, 006, 498	3, 366, 59		0. 000000	1
	6001 BLOOD LABORATORY	0	0		0. 000000	0. 000000	
1	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000	0. 000000	1
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	,	0. 000000	0. 000000	
1	6300 BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0. 000000	1
	6400 INTRAVENOUS THERAPY	0	0	,	0. 000000	0. 000000	1
	6500 RESPI RATORY THERAPY	0	0	,	0. 000000	0. 000000	
	6600 PHYSI CAL THERAPY	0	0	,	0. 000000	0. 000000	
	6700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0. 000000	1
	6800 SPEECH PATHOLOGY	0	0	,	0. 000000	0. 000000	
	6900 ELECTROCARDI OLOGY	205, 725	560, 013	765, 73		0. 000000	
	7000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	1
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	1
	7300 DRUGS CHARGED TO PATIENTS	158, 409	773, 663	932, 07		0. 000000	
	7400 RENAL DIALYSIS	0	0	•	0. 000000	0. 000000	
	7500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0. 000000	1
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0.000000	0. 000000	77. 00
	UTPATIENT SERVICE COST CENTERS			1			
1	9000 CLI NI C	0	0		0. 000000	0. 000000	
	9100 EMERGENCY	195, 556	7, 064, 070			0. 000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 937	165, 011			0. 000000	
200.00	Subtotal (see instructions)	1, 682, 462	19, 601, 916	21, 284, 37	В		200.00
201.00	Less Observation Beds				_[201. 00
202. 00	Total (see instructions)	1, 682, 462	19, 601, 916	21, 284, 37	В		202. 00

Health Financial Systems	FRANCISCAN BEACON HOSPIT	AL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi d	er CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/31/2022 2:38 pm

			10 12/31/2021	5/31/2022 2:3	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					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. 203305				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. 252688				60.00
60. 01 06001 BL00D 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 INTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 052331				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 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 302374				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					
90. 00 09000 CLI NI C	0. 000000				90. 00
91. 00 09100 EMERGENCY	0. 384484				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 163606				92. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	FRANCISCAN BEA	ACON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	CN: 15-0191	Period: From 03/24/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/31/2022 2:3	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Cos	ts RCE	Total Costs	

					To 12/31/2021	Date/Time Pre 5/31/2022 2:3	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
Cost Ce	nter 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	
	ITINE SERVICE COST CENTERS						
30. 00 03000 ADULTS		836, 224		836, 22	4 0	836, 224	30.00
	VICE COST CENTERS						
50. 00 05000 OPERATI		0			0	0	
51. 00 05100 RECOVER		0			0	0	51.00
52. 00 05200 DELI VER	Y ROOM & LABOR ROOM	0			0	0	52. 00
53. 00 05300 ANESTHE		0			0	0	53. 00
	GY-DI AGNOSTI C	1, 672, 615		1, 672, 61	5 0	1, 672, 615	54.00
	GY-THERAPEUTI C	0			0	0	55. 00
56. 00 05600 RADI 01 S	OTOPE	0			0	0	56. 00
57. 00 05700 CT SCAN		0			0	0	57. 00
58. 00 05800 MAGNETI	C RESONANCE IMAGING (MRI)	0			0	0	58. 00
59. 00 05900 CARDI AC	CATHETERI ZATI ON	0			0	0	59. 00
60. 00 06000 LABORAT	ORY	850, 698		850, 698	3 0	850, 698	60.00
60. 01 06001 BL00D L	ABORATORY	0			0	0	60. 01
61.00 06100 PBP CLI	NICAL LAB SERVICES-PRGM ONLY	0			0	0	61. 00
62. 00 06200 WHOLE E	LOOD & PACKED RED BLOOD CELLS	0			0	0	62.00
63. 00 06300 BL00D S	TORING, PROCESSING & TRANS.	0			0	0	63.00
64. 00 06400 I NTRAVE	NOUS THERAPY	O			0	0	64. 00
65. 00 06500 RESPI RA	TORY THERAPY	O	0		0	0	65. 00
66. 00 06600 PHYSI CA	L THERAPY	o	0		0	0	66. 00
67. 00 06700 OCCUPAT	I ONAL THERAPY	o	0		0	0	67.00
68. 00 06800 SPEECH	PATHOLOGY	o	0		0	0	68. 00
69. 00 06900 ELECTRO	CARDI OLOGY	40, 072		40, 07	2 0	40, 072	69. 00
	ENCEPHALOGRAPHY	o			0	0	1
	SUPPLIES CHARGED TO PATIENTS	o			0	0	71. 00
72.00 07200 I MPL. D	EV. CHARGED TO PATIENTS	ol		1	0	0	72. 00
	HARGED TO PATIENTS	281, 834		281, 83	4 0	281, 834	
74. 00 07400 RENAL D		0			0	0	
	N-DISTINCT PART)	0			0	0	
	EIC STEM CELL ACQUISITION	0			0	0	77. 00
	RVICE COST CENTERS	-1			-1		
90. 00 09000 CLI NI C		0			0	0	90.00
91. 00 09100 EMERGEN	CY	2, 791, 213		2, 791, 21	3 0	2, 791, 213	
	TION BEDS (NON-DISTINCT PART)	231, 497		231, 49		231, 497	
	I (see instructions)	6, 704, 153	0	1		6, 704, 153	
	servation Beds	231, 497		231, 49		231, 497	
	see instructions)	6, 472, 656	0				
1 1	,				-1		

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-019	Peri od: Worksheet C From 03/24/2021 Part I To 12/31/2021 Date/Time Prepared:

					To 12/31/2021	Date/Time Pre 5/31/2022 2:3	pared: 8 pm
			Titl	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	
	T	6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00	03000 ADULTS & PEDI ATRI CS	534, 273		534, 27	3		30.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	(0. 000000		
51. 00	05100 RECOVERY ROOM	0	0	(0. 000000		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0. 000000		1
53. 00	05300 ANESTHESI OLOGY	0	0	(0.000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	194, 464	8, 032, 661	8, 227, 12		0. 000000	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0. 000000	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0	(0. 000000	0. 000000	1
57. 00	05700 CT SCAN	0	0	(0. 000000	0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(0. 000000	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0. 000000	0. 000000	
60.00	06000 LABORATORY	360, 098	3, 006, 498	3, 366, 59		0. 000000	1
60. 01	06001 BLOOD LABORATORY	0	0	(0. 000000	0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	(0. 000000	0. 000000	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0. 000000	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0. 000000	0. 000000	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	(0. 000000	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0	(0. 000000	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0	(0. 000000	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0. 000000	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0	(0. 000000	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	205, 725	560, 013	765, 73		0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0.000000	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0. 000000	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0. 000000		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	158, 409	773, 663	932, 07:		0. 000000	
	07400 RENAL DI ALYSI S	0	0		0. 000000	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0. 000000	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(0.000000	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
	09000 CLI NI C	0	0		0. 000000		
	09100 EMERGENCY	195, 556	7, 064, 070			0. 000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 937	165, 011			0. 000000	1
200.00		1, 682, 462	19, 601, 916	21, 284, 37	3		200. 00
201.00	l l						201. 00
202.00	Total (see instructions)	1, 682, 462	19, 601, 916	21, 284, 37	3		202. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/31/2022 2:38 pm

				5/31/2022 2:38 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG 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. 000000			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 I MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
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 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
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	0.00000			77.00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
200.00 Subtotal (see instructions)	0.000000			200. 00
201. 00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
202. 00 Total (See Histiactions)				1202.00

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 03/24/2021 To 12/31/2021	Part I Date/Time Pre	nared.
				10 12/01/2021	5/31/2022 2: 3	8 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	435, 479	C	435, 47			30.00
200.00 Total (lines 30 through 199)	435, 479		435, 47	9 354		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 ADULTS & PEDIATRICS	115		1			30. 00
200.00 Total (lines 30 through 199)	115	141, 470)			200. 00

Health Financial Systems	FRANCISCAN BEA	ACON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der (CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/31/2022 2:3	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	(from Wkst. C	9	Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM	C		0.0000		0	50.00

	Cost Center Description	Capi tal		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		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		292, 334	8, 227, 125	0. 035533	90, 166	3, 204	54.00
55.00		0	0	0.000000	0	0	55. 00
56.00		0	0	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	27, 400	3, 366, 596	0. 008139	196, 758	1, 601	60.00
60. 01	06001 BLOOD 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	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.000000	0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0	0	0.000000	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0.000000	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.000000	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	14, 893	765, 738	0. 019449	106, 510	2, 072	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	0	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	12, 975	932, 072	0. 013921	70, 722	985	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0. 000000	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0. 000000	0	0	75. 00
77. 00	1 1 7	0	0	0. 000000	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			'			
90.00		0	0	0.000000	0	0	90. 00
91.00	I I	329, 615	7, 259, 626		100, 180	4, 549	
92.00	I I	120, 556			21, 914		
200.0		797, 773			586, 250		
			•			•	•

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Li∈	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	rs Provider C		Period: From 03/24/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/31/2022 2:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	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	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	200.00
	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	35- 35-			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	FRANCISCAN BEACON HOSPITAL	_ In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider	CCN: 15-0191 Peri od:	Worksheet D
THROUGH COSTS		From 03/24/2021	

				To 12/31/2021		
		Ti +l c	xVIII	Hospi tal	5/31/2022 2: 3 PPS	в рііі
Cost Center Description	Non Physician	Nursi ng	Nursing		Allied Health	
oust defiter bescription	Anesthetist	Program	Program	Post-Stepdown	Airrea nearth	
	Cost	Post-Stepdown	l rrogram	Adjustments		
	0001	Adjustments		riaj ao emorreo		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS					2.00	
50. 00 05000 OPERATING ROOM	0	0		0 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	1	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56. 00 05600 RADI 01 SOTOPE	0	0		0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (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	1	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	1	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	1	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	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	1	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	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 PATIENTS	0	0	•	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	•	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	1	0		75. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLI NI C	0		1	0		
91. 00 09100 EMERGENCY	0	0	•	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,	1	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	1 0	200. 00

Health Financial Systems	FRANCISCAN BEACC	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER PASS	Provider Co		Period: From 03/24/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	pared:
					5/31/2022 2: 3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medical (sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost 1	, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols 2 3	8)	7)	

						5/31/2022 2:3	8 pm
			Titl∈	: XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C		0 0	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0	Ö		o o	0.000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	O		o o	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		ol o	0. 000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	Ó		0 8, 227, 125		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ó		o o	0.000000	
56. 00	05600 RADI OI SOTOPE	0	0		0	0.000000	1
57. 00	05700 CT SCAN	0	Ö		0	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ö		0	0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö		0	0. 000000	
60. 00	06000 LABORATORY	0	0		0 3, 366, 596		
60. 01	06001 BLOOD LABORATORY	0			0 3, 300, 370	0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0.00000	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	Ō			0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0.000000	
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0.00000	
65. 00	06500 RESPIRATORY THERAPY	0			0	0.00000	
		0			0		
66.00	06600 PHYSI CAL THERAPY	0			0	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0.000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0.000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 765, 738		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	
		0	0		0 0	0. 000000	
		0	0		0	0. 000000	
73.00		0	0		0 932, 072		
		0	0		0		
		0	0		0	0.000000	75. 00
77. 00		0	0		0 0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
		0	O		0 0	0. 000000	90. 00
91.00	09100 EMERGENCY	0	0		0 7, 259, 626	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 198, 948	0.000000	92.00
200.00	Total (lines 50 through 199)	o	0		0 20, 750, 105		200. 00

Health Financial Systems	FRANCI SCAN BEACON	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CC		Peri od: From 03/24/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prep 5/31/2022 2:38	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpati ent Program	
	to Charges (col. 6 ÷ col.	Charges	Pass-Through Costs (col.		Pass-Through Costs (col. 9	

		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	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 O5100 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	90, 166	o	2, 617, 649	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	o	0	0	55. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000	0	О	0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	0	o	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	o	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	l o	0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	196, 758	o	28, 993	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	o	0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	o	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	o	0	0	64. 00
65, 00 06500 RESPIRATORY THERAPY	0. 000000	0	o	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	o	0	0	66, 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	o	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	o	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	106, 510	o	261, 059	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	o	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	o	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	o	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	70, 722	o	334, 461	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	0	o	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	o	0	0	75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	o	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS			· -1	-		
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90. 00
91. 00 09100 EMERGENCY	0. 000000	100, 180		2, 017, 567	Ö	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	21, 914		67, 571	Ö	92. 00
200.00 Total (lines 50 through 199)		586, 250			0	200. 00
	1	* * * * * * * * * * * * * * * * * * * *	'			

Cost Center Description	APP0R1	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
Cost Center Description						From 03/24/2021 To 12/31/2021	Part V	nared·
Title XVIII						10 12/31/2021	5/31/2022 2: 3	8 pm
Cost Center Description				Title	: XVIII	Hospi tal		
Ratio From Morksheet C, Part I, col. Part I							Costs	
Ratio From Morksheet C, Part I, col. Part I		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
MORKSHEEL C. Part I . col . Part I								
ANCILLARY SERVICE COST CENTERS							(, , , , , , , , , , , , , , , , , , ,	
ANCILLARY SERVICE COST CENTERS			Part I, col. 9	ĺ	Subject To	Subject To		
ANCILLARY SERVICE COST CENTERS					Ded. & Coins.	Ded. & Coins.		
ANCILLARY SERVICE COST CENTERS					(see inst.)	(see inst.)		
SOLOO			1.00	2.00	3.00		5. 00	
51.00 05100 RECOVERY ROOM 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000		ANCILLARY SERVICE COST CENTERS				•		
S2.00 053000 053000 053000 053000 053000 053000 053000 053000 0530	50.00	05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50. 00
S3.00 05300 ABUSTHESI OLOCY 0.000000 0 0 0 53.0	51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
S3.00 05300 ABUSTHESI OLOCY 0.000000 0 0 0 53.0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	l o		0	l o	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.203305 2.617, 649 0 0 532, 181 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 0 0	53.00	05300 ANESTHESI OLOGY	0. 000000	l o		0	l o	53.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55. 00		I I				0	532, 181	54.00
56.00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 56.00						0		
57.00 05700 CT SCAN 0.000000 0 0 0 0 57.00						-	1	1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 0000000 0 0 0 0 58. 00 59. 00 05900 CARDI AC CARTHETER ZATI ON 0. 0000000 0 0 0 0 59. 00 60. 01 06000 LABORATORY 0. 252688 28, 993 0 0 7, 326 60. 01 06001 BLOOD LABORATORY 0. 000000 0 0 0 0 61. 00 06100 PBP CLINI CAL LAB SERVICES-PRGM ONLY 0. 000000 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0. 0000000 0 0 0 0 64. 00 06400 INTRAVRONUS THERAPY 0. 0000000 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0. 0000000 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0. 0000000 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0. 0000000 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 0. 0000000 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOCY 0. 052331 261,059 0 0 0 13,611 69,000 71. 00 07000 ELECTROENCEPHALOGRAPHY 0. 0000000 0 0 0 0 0 72. 00 07000 ELECTROENCEPHALOGRAPHY 0. 0000000 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 0 0 0 0 0 74. 00 07500 ASC (NON-DI STI NCT PART) 0. 0000000 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0. 0000000 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0. 0000000 0 0 0 0 75, 702 79. 00 07000 ELEGRENICY STEW CELL ACQUISITION 0. 0000000 0 0 0 0 75, 702 79. 00 07000 ELEGRENICY STEW CELL ACQUISITION 0. 0000000 0 0 0 775, 702 79. 00 07000 ELEGRENICY 0. 0000000 0 0 0 0 775, 702 79. 00 07000 CLINIC CEST CENTERS 0. 0000000 0 0 0 0 775, 702 79. 00 07000 CLINIC CEST CENTERS 0. 0000000 0 0 0 0 775, 702 79. 00 07000 CLINIC CLI		1 1				-	1	
59, 00 05900 CARDIAC CATHETERIZATION 0,000000 0 0 0 0 59, 00		I I	· ·			-	1	1
60.00 06000 LABORATORY 0.252688 28,993 0 0 7,326 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 0 0 61.00 06100 PSP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0.000000 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0.000000 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0.000000 0 0 0 0 67.00 06700 0CUPATIONAL THERAPY 0.000000 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0.000000 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0.052331 261,059 0 0 13,661 69.00 71.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 72.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 77.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 77.00 07500 CLECTROENCEPHERS 0.000000 0 0 0 77.00 07000 ELECTROENCEPHERS 0.000000 0 0 0 77.00 07000 CLINIC 0.000000 0 0 0 0 77.00 07			N .			9		
60.01 60.01 BLOOD LABORATORY 0.000000 0 0 0 60.01 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0.000000 0 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 0 0 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0.000000 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0.000000 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0.052331 261,059 0 0 13,661 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.302374 334,461 0 817 101,132 73.00 74.00 07400 RENAL DI ALYSIS 0.000000 0 0 0 0 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 0 77.00 07700 ALLOGRAPIC STEM CELL ACQUI SI TI ON 0.000000 0 0 0 0 791.00 07000 EMERGENCY 0.384484 2,017,567 0 0 775,722 91.00 792.00 09000 CLI NI C 0 0 0 78,626 92.00 791.00 09000 CLI STEM CELL ACQUI SI TI NCT PART) 1.163606 67,571 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 0 0 78,626 92.00 791.00 09000 CLI NI C 0 0 0 0 0 0 0 0 0			· ·			9		1
61. 00			1		•	9		1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0.000000 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.302374 334, 461 0 817 101, 132 73. 00 74. 00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 77. 00 007000 CLINIC 0.000000 0 77. 00 007000 CLINIC 0.000000 0 77. 00 007000 CLINIC 0.000000 0 78. 626 92. 00 79. 00 00900 CLINIC 0.000000 0 0 78. 626 92. 00 78. 627, 300 0.000000 0 0 78. 628 92. 00 78. 629 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620 92. 00 78. 620			1			0	1	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 63. 00 64. 00 06400 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 SPECH PATHOLOGY 0.000000 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.052331 261,059 0 0 13,661 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0.000000 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.302374 334,461 0 817 101,132 73. 00 74. 00 07400 RENAL DI ALYSI S 0.000000 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 0 77. 00 07100 MERIGENEIC STEM CELL ACQUISITION 0.000000 0 0 0 0 90. 00 09100 ERRGENCY 0.384484 2,017,567 0 0 775,722 91. 00 91. 00 09100 ERRGENCY 0.384484 2,017,567 0 0 775,722 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.163606 67,571 0 0 78,626 92. 00 91. 00 Only Charges 0 0 0 0 0 91. 00 Only Charges 0 0 0 0 91. 00 Only Charges 0 0 0 91. 00 0 0 0 92. 00 0 0 0 0 93. 00 0 0 0 94. 00 0 0 0 95. 00 0 0 0 96. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00 0 0 0 97. 00			1			9	•	
64. 00			1	ł .		-	1	1
65. 00 06500 RESPIRATORY THERAPY 0.000000 0 0 0 0 65. 00 66. 00			1			9	1	1
66. 00			1			-	1	1
67. 00		i i	1			<u> </u>		1
68. 00		I I	1			<u> </u>		1
69. 00 06900 ELECTROCARDI OLOGY 0. 052331 261, 059 0 0 13, 661 69. 00 70. 0		1 1	1	l e		<u> </u>		
70. 00		I I	1	ł .		0		1
71. 00		i i	1		1	0		
72. 00 07200 1 MPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 0.302374 334, 461 0 817 101, 132 73. 00 74. 00 74. 00 74. 00 75. 00		I I	1	ł .	1	9	1	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 302374 334, 461 0 817 101, 132 73. 00 74. 00 74. 00 74. 00 75. 00 0. 000000 0 0 0 0 0 0			1	l e	1	-	1	
74. 00					1	٥		1
75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 0 0 75. 00 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90. 00 09100 CLINIC 0.000000 0 0 0 0 0 91. 00 09100 EMERGENCY 0.384484 2,017,567 0 0 775,722 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.163606 67,571 0 0 775,826 92. 00 200. 00 Subtotal (see instructions) 5,327,300 0 817 1,508,648 200. 00 201. 00 Only Charges		I I						
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0.000000 0 0 0 0 0 0 0					1	<u> </u>		1
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Health Financial Systems	FRANCISCAN BEACON	I HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER H	EALTH SERVICES AND VACCINE COST	Provider CCN: 15-0191	From 03/24/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/31/2022 2:38 pm
		Ti +Lo YVIII	Hospi tal	DDS

				To 12/31/2021	Date/Time Pre 5/31/2022 2:3	pared:
		Ti tl e	: XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	l			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	O)			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	O)			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	1			60.00
60. 01 06001 BLOOD LABORATORY	0	0	1			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	1			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0					65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0		1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	Ö	1			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	1			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	247				73. 00
74.00 07400 RENAL DIALYSIS	0	o)			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	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	0	0	1			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
200.00 Subtotal (see instructions)	0	247				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges (Line 200 Line 201)		247				202 00
202.00 Net Charges (line 200 - line 201)	1	247	I			202. 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 03/24/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/31/2022 2:3	pared: 8 pm
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

PART 1. ALL PROVIDED COMENNETS 1.00 Impatient days (including private room days and swing-bed days, excluding newborn) 354 2.00			Title XVIII	Hospi tal	PPS	
INPATIENT DAYS INPA		Cost Center Description			1 00	
Inpatt ent days (including private room days and sain g-bed days, excluding needern) 354 2.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (Including private room days, excluding swing-bed and neaborn days) 3.6 2.00						
private room days (excluding saing-bed and observation bed days). If you have only private room days (excluding saing-bed and observation bed days). 250 do not complete this line. 4.00 Sell-private room days (excluding saing-bed and observation bed days). 5.00 Total saving-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Total saving-bed MF 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 Total saving-bed MF 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 Total inpatient days including private room days patient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and nowborn days) (see instructions). 7.00 Saving-bed SMF type inpatient days applicable to title XMII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Saving-bed SMF type inpatient days applicable to title XMII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Saving-bed SMF type inpatient days applicable to title XMII only (including private room days). 7.00 Total nursery days (title V or XIX only) (including private room days). 7.00 Total nursery days (title V or XIX only). 7.00 Total nursery days (title V or XIX only). 7.00 Total nursery days (title V or XIX only). 7.00 Total nursery days (title V or XIX only). 7.00 Total nursery days (title V or XIX only). 7.00 Total nursery days (title V or XIX only). 7.00 Total nursery days (title V or XIX only). 7.00 Total nursery days (title V or XIX only). 7.00 Total applica						
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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 836, 224 and 92 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 (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
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 836, 224 37.00 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nus line 33)(see instruct	tions)		
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 836, 224 37.00 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) 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 36.00 836.00		, , ,	, ,	11 0/13)		
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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 27.00		,	IC 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 362.21 38.00 Program general inpatient routine service cost (line 9 x line 38) 271,654 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	and private room cost dif	Fferential (line	-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 362.21 38.00 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 dit	rerential (Tine	830, 224	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 362.21 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						
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) 271,654 39.00 40.00			JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		2, 362. 21	38. 00
	39. 00	Program general inpatient routine service cost (line 9 x line	38)		271, 654	39. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 271,654 41.00	40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		271, 654	41. 00

	Financial Systems TATION OF INPATIENT OPERATING COST	FRANCISCAN BEAC	Provider C	CN: 15 0101	Period:	u of Form CMS-2 Worksheet D-1	
COMPU	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0191	From 03/24/2021		
					To 12/31/2021	Date/Time Pre 5/31/2022 2:3	pared: 8 pm
	Coat Contar Decement on	Total		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1	3	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units	S					
43. 00 44. 00	INTENSIVE CARE UNIT						43.00
45. 00							45. 00
46.00	1						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48.00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			nns)		159, 024 430, 678	1
47.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 40) (3	see mistructio	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		430, 070	47.00
50.00	Pass through costs applicable to Program in	patient routine s	services (from	n Wkst. D, sur	n of Parts I and	141, 470	50.00
51. 00		patient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	25, 690	51.00
	and IV)		•				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		ated non-phy	vsician anesth	netist and	167, 160 263, 518	1
00.00	medical education costs (line 49 minus line				Totrot, and	200, 010] 55. 55
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55. 00
56.00	,				50)		56.00
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ting cost and tar	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	endi ng 1996, ເ	pdated and co	ompounded by the	_	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	dated by the m	arkat haskat		0.00	60.00
61. 00	1				the amount by	0.00	1
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	f the target		
62. 00	Relief payment (see instructions)	riisti ucti olis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive pay	ment (see instruc	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Decem	nber 31 of the	cost reporti	ing period (See	0	64. 00
/ F 00	instructions)(title XVIII only)		04 6 11				/ 5 00
65. 00	Medicare swing-bed SNF inpatient routine con instructions)(title XVIII only)	sts after Decembe	er 31 or the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	64 plus line 6	5)(title XVII	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	of the cost re	eporting period	0	67.00
	(line 12 x line 19)	0					
68. 00	Title V or XIX swing-bed NF inpatient routil (line 13 x line 20)	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	: 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci				<u> </u>		70.00
71.00	Adjusted general inpatient routine service)		71.00
72.00	,		(1: 14 1:	25)			72.00
73. 00 74. 00	Medically necessary private room cost applicated Program general inpatient routine ser						73.00
75. 00	Capital-related cost allocated to inpatient	•			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 line						77. 00
78.00	,		soulder record	le)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		79. 00 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	nstructions)					84. 00
85.00	Utilization review - physician compensation Total Program inpatient operating costs (su						85. 00 86. 00
86 00	protar riogram impatrent operating costs (Su	m or rings os thi	ough obj				1 00.00
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST					
86. 00 87. 00 88. 00	Total observation bed days (see instruction	s)	11: 2)			98 2, 362. 21	1

Health Financial Systems	FRANCISCAN 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 03/24/2021 To 12/31/2021	Date/Time Prep 5/31/2022 2:38	
		Title	XVIII	Hospi tal	PPS	
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	435, 479	836, 224	0. 52076	8 231, 497	120, 556	90.00
91.00 Nursing Program cost	0	836, 224	0.00000	231, 497	0	91.00
92.00 Allied health cost	0	836, 224	0.00000	231, 497	0	92. 00
93.00 All other Medical Education	0	836, 224	0.00000	231, 497	0	93. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0191	Period: From 03/24/2021	Worksheet D-1
		To 12/31/2021	Date/Time Prepared: 5/31/2022 2:38 pm
	Title XIX	Hospi tal	Cost
Cost Center Description			

		Title XIX	Hospi tal	5/31/2022 2: 38 Cost	8 pm
	Cost Center Description	THE XIX	позрі саі		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days			354	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bervate room days (excluding swing-bed and observation bed day		ivate room days	354	2. 00 3. 00
3.00	do not complete this line.	73). IT you have only pr	rvate room days,	ا	3.00
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	256	4.00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 or the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	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	n days) through December	31 of the cost	0	7. 00
7.00	reporting period	r days) thi odgir becember	31 of the cost	1	7.00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1	9.00
	newborn days) (see instructions)		· ·	·	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10.00
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		a maam daya)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI> through December 31 of the cost reporting period	confy (including private	e room days)	ا ا	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI>			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)	an (exertaining swring bear	udy3)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	<u> </u>		1	
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	836, 224 0	21. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	01 of the cost reporting	pariod (line 9	0	25. 00
25.00	x line 20)	of the cost reporting	perrou (Trile o	ا ا	25.00
26. 00	Total swing-bed cost (see instructions)	(1: 04 : 1: 04)		0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		836, 224	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 :	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	and anticote	Efononti - L (L)	027 224	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rrentral (line	836, 224	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			2 2/2 21	1 20 22
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 362. 21	
40. 00	Medically necessary private room cost applicable to the Progra	,		2, 362 0	1
	Total Program general inpatient routine service cost (line 39	•			41.00

	Financial Systems	FRANCISCAN BEAG		CN: 1E 0101		u of Form CMS-	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der C	UN: 15-U191	Period: From 03/24/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	
						5/31/2022 2: 3	18 pm
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost conton poson per on	Inpatient Cost		Diem (col. 1	3	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	0.00	1. 00	0.00	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unite	5					43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description			I .			47.00
40.00	D	l+ D 21 2	11: 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ons)		0 2. 362	48. 00 49. 00
	PASS THROUGH COST ADJUSTMENTS	-					
50. 00	Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50.00
51.00	Pass through costs applicable to Program in	patient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV)	EO and E1)				0	52. 00
53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated, non-phy	sician anestl	netist, and	0	
	medical education costs (line 49 minus line	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0. 00	55. 00
56. 00 57. 00	, ,	ting cost and ta	raet amount (1	ine 56 minus	line 53)	0 0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	tring cost and ta	rget amount (i	THE 50 IIITHUS	111le 33)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost r	eporting period	endi ng 1996, ເ	ipdated and co	ompounded by the	0.00	59. 00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of lin	es 55, 59 or 60	enter the less	er of 50% of		0	61. 00
	which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	f the target		
	Relief payment (see instructions)	•				0	
63. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ctions)			0	63. 00
64.00		sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	sts after Decemb	or 21 of the c	ost roportin	a ported (Soc	0	65. 00
03.00	instructions) (title XVIII only)	sts after beceilib	er 31 or the c	ost reporting	g perrou (see		05.00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line 6	5)(title XVI	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	9					
68. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci				1		70.00
71. 00	Adjusted general inpatient routine service				,		71. 00
72.00	,		(line 14 v !:	no 3E)			72.00
73. 00 74. 00	Medically necessary private room cost appli Total Program general inpatient routine ser						73.00
75. 00	Capital-related cost allocated to inpatient	,			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						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		rovi don rocoro	le)			78. 00 79. 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	nstructions)					84. 00
85. 00 86. 00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PAS		rougir ob)				86. 00
							-
87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	•	11: 2)			98 2, 362. 21	1

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 03/24/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Prep 5/31/2022 2:38	
		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	435, 479	836, 224	0. 52076	8 231, 497	120, 556	90.00
91.00 Nursing Program cost	0	836, 224	0.00000	231, 497	0	91.00
92.00 Allied health cost	0	836, 224	0.00000	231, 497	0	92.00
93.00 All other Medical Education	0	836, 224	0.00000	231, 497	0	93.00

PATI EI	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0191	Peri od: From 03/24/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Pre 5/31/2022 2:3	pare 8 pr
		Title	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
l l	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	03000 ADULTS & PEDIATRICS			251, 291		30
	NCI LLARY SERVI CE COST CENTERS			251, 271		1 30
	05000 OPERATI NG ROOM		0.00000	00 00	0	50
	05100 RECOVERY ROOM		0.00000		0	
	DELIVERY ROOM & LABOR ROOM		0.00000		0	
	05300 ANESTHESI OLOGY		0.00000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 20330		18, 331	5
00 0	05500 RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	5!
00 0	05600 RADI OI SOTOPE		0.00000	0 00	0	5
0 00	D5700 CT SCAN		0.00000	00 0	0	5
00 0	D5800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	00 0	0	5
00 0	05900 CARDI AC CATHETERI ZATI ON		0.00000	00	0	5
	06000 LABORATORY		0. 25268		49, 718	
	06001 BLOOD LABORATORY		0.00000		0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	1 -
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	
	06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
- 1	06400 NTRAVENOUS THERAPY		0.00000		0	
- 1	06500 RESPI RATORY THERAPY		0.00000		0	
	06600 PHYSI CAL THERAPY		0.00000		0	1 .
	06700 OCCUPATI ONAL THERAPY		0.00000		0	
- 1	06800 SPEECH PATHOLOGY		0.00000		0	
- 1	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0. 05233 0. 00000		5, 574 0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 3023		21, 384	
	07400 RENAL DIALYSIS		0. 00000		21, 304	
	07500 ASC (NON-DISTINCT PART)		0.00000		0	
	07700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000		0	
	OUTPATIENT SERVICE COST CENTERS		0.0000	90		1
	09000 CLI NI C		0.00000	00 00	0	90
	09100 EMERGENCY		0. 38448		38, 518	9
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 16360		25, 499	
. 00	Total (sum of lines 50 through 94 and 96 through 98))		586, 250	159, 024	200
1.00	Less PBP Clinic Laboratory Services-Program only cha			o		201
2. 00	Net charges (line 200 minus line 201)			586, 250		202

alth Financial Systems FRANCISCAN BEACON H PATIENT ANCILLARY SERVICE COST APPORTIONMENT P	rovider Co	CN: 15-0191	Peri od:	u of Form CMS-2 Worksheet D-3	
			From 03/24/2021 To 12/31/2021	Date/Time Pre 5/31/2022 2:3	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS			1		30.
ANCILLARY SERVICE COST CENTERS					
.00 05000 OPERATING ROOM		0. 00000	00	0	50.
.00 05100 RECOVERY ROOM		0. 00000		0	
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	1 .
. 00 05300 ANESTHESI OLOGY		0.0000		0	1
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20330		0	
. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
. 00 05600 RADI 0I SOTOPE		0.0000		0	
OO OSTOO CT SCAN		0.0000		0	1
. OO O5800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	
. 00 05900 CARDI AC CATHETERI ZATI ON . 00 06000 LABORATORY		0.00000		0	
. 00 06000 LABORATORY . 01 06001 BLOOD LABORATORY		0. 25268 0. 00000		0	
.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000		0	1
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	
. 00 06400 I NTRAVENOUS THERAPY		0. 00000		0	
00 06500 RESPIRATORY THERAPY		0. 00000		0	
. 00 06600 PHYSI CAL THERAPY		0. 00000		0	
. 00 06700 OCCUPATI ONAL THERAPY		0. 00000		0	1
. 00 06800 SPEECH PATHOLOGY		0. 00000		0	
. 00 06900 ELECTROCARDI OLOGY		0. 0523		0	
. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	71
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000	0 00	0	72
.00 07300 DRUGS CHARGED TO PATIENTS		0. 3023 ⁻	74 0	0	73
. 00 07400 RENAL DIALYSIS		0. 00000	00 00	0	74
.00 07500 ASC (NON-DISTINCT PART)		0.0000	00	0	75
. OO O7700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000	00 0	0	77
OUTPATIENT SERVICE COST CENTERS					
. 00 09000 CLI NI C		0. 00000		0	1
. 00 09100 EMERGENCY		0. 38448		0	
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 16360		0	
Total (sum of lines 50 through 94 and 96 through 98)			0	0	200
1.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201
2.00 Net charges (line 200 minus line 201)			0		202

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 Part A Date/Time Prepared: 5/31/2022 2:38 pm

		T: +1 - \\\\ 1		5/31/2022 2: 3	8 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			-	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	0 283, 765	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	0	1. 02		
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			0	2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructi	one)		0	2. 01 2. 02
2. 02	Outlier payments for discharges occurring prior to October 1 (0	2. 02
2. 04	Outlier payments for discharges occurring on or after October			0	2. 04
3.00	Managed Care Simulated Payments	,		0	3. 00
4.00	Bed days available divided by number of days in the cost repor	ting period (see instruc	ctions)	7. 63	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting p	period ending on	0.00	5. 00
	or before 12/31/1996. (see instructions)	a aritaria far an add a	. +a +ba aan far	0.00	4 00
6.00	FTE count for allopathic and osteopathic programs that meet th new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified u ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slo under § 5506 of ACA. (see instructions)	ts from a closed teachin	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (s	see	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent year from your record	ds	0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12. 00	Current year allowable FTE (see instructions)				12. 00
13.00	Total allowable FTE count for the prior year.		hh 20 1007	0.00	
14. 00	Total allowable FTE count for the penultimate year if that yea otherwise enter zero.	ir ended on or after Sept	tember 30, 1997,	0.00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18.00	Adjusted rolling average FTE count				18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4)			0.000000	
20.00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	21. 00 22. 00
22. 00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	22. 00
22.01	Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA			22.01
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.		FR 412. 105	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	24 (see	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	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	`		0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment	<u> </u>		0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	itient days (see instruct	tions)	0.00	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	daya (300 Filati do		0.00	31.00
32. 00	Sum of lines 30 and 31			0.00	32. 00
33. 00	Allowable disproportionate share percentage (see instructions)			0.00	
34. 00	Disproportionate share adjustment (see instructions)			0	34. 00

	Financial Systems FRANCISCAN BEACO ATION OF REIMBURSEMENT SETTLEMENT	N HOSPITAL Provider CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre	pared:
		T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11: 4-1	5/31/2022 2: 3	8 pm
		Title XVIII	Hospital Prior to 10/1	PPS On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35. 00
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	e 0	0	35. 02
25 02	instructions)			0	25 02
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amo Total uncompensated care (sum of columns 1 and 2 on line 35.0		0	0	35. 03 36. 00
30.00	Additional payment for high percentage of ESRD beneficiary di				30.00
40. 00	Total Medicare discharges (see instructions)	conarges (Times to times	0		40. 00
41.00	Total ESRD Medicare discharges (see instructions)		0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct	i ons)	0		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)		0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instructions	.)	0.00		45. 00
	Total additional payment (line 45 times line 44 times line 41		0.00		46. 00
47. 00	Subtotal (see instructions)		283, 765		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48. 00
	only. (see instructions)	·			
				Amount	
10.00		,		1.00	10.00
49.00	Total payment for inpatient operating costs (see instructions	· ·		283, 765	1
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.			142, 086 0	50. 00 51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			0	52.00
53. 00	Nursing and Allied Health Managed Care payment	The Tribut detroils).		0	53. 00
54. 00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intr	•		0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57. 00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, Col. II line 200)		0 425, 851	58. 00 59. 00
60.00	Primary payer payments			425, 651	60.00
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		425, 851	61. 00
62.00	Deductibles billed to program beneficiaries	,		50, 456	ı
63.00	Coinsurance billed to program beneficiaries			0	63. 00
64. 00	Allowable bad debts (see instructions)			0	64. 00
65. 00	Adjusted reimbursable bad debts (see instructions)			0	65. 00
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	66.00
67.00	,	anni achia ta MC DDCa (a	oo imatmuatiana)	375, 395	1
69.00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(101 301 3ee 1113ti deti on	3)	0	1
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration	, , ,		0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89		ructions)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0	70. 92
70 00				()	70. 93
70. 93 70. 94	HRR adjustment amount (see instructions)			0	70. 94

	Financial Systems	FRANCISCAN BEACON				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider Co	CN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/31/2022 2:3	pared: 8 pm
			Title	XVIII	Hospi tal	PPS	Орш
					(уууу)	Amount	
					0	1.00	
70. 96	Low volume adjustment for federal fiscal year	ar (yyyy) (Enter i	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period Low volume adjustment for federal fiscal year the corresponding federal year for the period	ar (yyyy) (Enter i			0	0	70. 97
70. 98	Low Volume Payment-3	od charring on or ar	10/1/			0	70. 98
70. 99	HAC adjustment amount (see instructions)					0	
71. 00		plus/minus lines	59 & 70)			375, 395	
71. 01	Sequestration adjustment (see instructions)		,			0	71. 01
71. 02	Demonstration payment adjustment amount after	er sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-through						71. 03
72.00	Interim payments					254, 232	72. 00
72. 01	Interim payments-PARHM						72. 01
73. 00	Tentative settlement (for contractor use on	y)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor	J,					73. 01
74. 00	Balance due provider/program (line 71 minus 73)	lines 71.01, 71.0	2, 72, and			121, 163	74. 00
74. 01	Balance due provider/program-PARHM (see ins	tructions)					74. 01
75. 00	Protested amounts (nonallowable cost report CMS Pub. 15-2, chapter 1, §115.2		nce with			0	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 thro						
90. 00	Operating outlier amount from Wkst. E, Pt. , plus 2.04 (see instructions)	A, line 2, or sum (of 2.03			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2					0	, 00
	Operating outlier reconciliation adjustment	•	,			0	
93.00	Capital outlier reconciliation adjustment a					0	
	The rate used to calculate the time value of		uctions)			0.00	
96. 00 96. 00	Time value of money for operating expenses Time value of money for capital related exp	` ,	ti onc)			0	
70.00	Titille value of money for capital related exp	clises (see Flistruc	LI OHS)		Prior to 10/1		70.00
					1. 00	2.00	
	HSP Bonus Payment Amount				1.00	2.00	
100.00	HSP bonus amount (see instructions)				0	0	100.00
	HVBP Adjustment for HSP Bonus Payment						
101.00	HVBP adjustment factor (see instructions)				0.0000000000	0.000000000	101. 00
102.00	HVBP adjustment amount for HSP bonus paymen	t (see instructions	s)		0	0	102. 00
	HRR Adjustment for HSP Bonus Payment						1
103.00	HRR adjustment factor (see instructions)				0.0000	0.0000	103. 00
104.00	HRR adjustment amount for HSP bonus payment				0	0	104. 00
	Rural Community Hospital Demonstration Proje						1
200.00	Is this the first year of the current 5-year		riod under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N"	for no.					1
201 00	Cost Reimbursement	D 1 D+ 11 11	- 40)				201 00
	Medicare inpatient service costs (from Wkst.	υ-I, PT. II, IIn	e 49)				201. 00
	Medicare discharges (see instructions)	-)					202. 00 203. 00
∠∪3. UU	Case-mix adjustment factor (see instructions	>/					J∠U3. UU

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)	ļ.		
91.00 Capital outlier from Wkst. L, Pt. I, line 2		l ol	91.00
92.00 Operating outlier reconciliation adjustment amount (see instructions)	ļ.	l ol	
93.00 Capital outlier reconciliation adjustment amount (see instructions)	!	l ol	
94.00 The rate used to calculate the time value of money (see instructions)	ļ.	0.00	
95.00 Time value of money for operating expenses (see instructions)	ļ.	0.00	
96.00 Time value of money for capital related expenses (see instructions)	ļ		
96. 00 If the value of money for capital related expenses (see instructions)	D:: -:- +- 10/1	-	96.00
	Prior to 10/1		
lico o	1. 00	2. 00	
HSP Bonus Payment Amount		_	4
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 0000000000		
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0		104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Rei mbursement			i
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202.00
203.00 Case-mix adjustment factor (see instructions)	1.5		203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curre	ent 5-year demonst	tration	
peri od)			4
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00 Adjustment to Medicare IPPS payments (see instructions)	!		209. 00
210.00 Reserved for future use			210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)			210.00
(Time 212 minus Time 213) (See Thistructions)	l l		l

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/31/2022 2:38 pm

		Title XVIII	Hospi tal	5/31/2022 2: 38 PPS	8 pm
			oop. tu.		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			247	1.00
1	Medical and other services reimbursed under OPPS (see instructions))		1, 508, 648	
	OPPS payments	,		856, 942	1
4.00	Outlier payment (see instructions)			2, 217	4.00
	Outlier reconciliation amount (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instructions	s)		0.000	
4	Line 2 times line 5			0.00	
1	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	ol. 13. line 200		0	1
	Organ acqui si ti ons			0	1
	Total cost (sum of lines 1 and 10) (see instructions)			247	11. 00
H	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable charges			017	12 00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	٥)		817	1
	Total reasonable charges (sum of lines 12 and 13)	7)		817	1
	Customary charges			-	1
15. 00	Aggregate amount actually collected from patients liable for paymer	nt for services on a	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payr	ment for services o	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17. 00
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 817	
	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	570	
	instructions)		, (
	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds lin	ne 18) (see	0	20.00
	instructions)			0.47	04.00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			247	1
	Cost of physicians' services in a teaching hospital (see instructions)	ons)			1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0.10)		859, 159	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
	Deductibles and Coinsurance amounts relating to amount on line 24			155, 002	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus tinstructions)	the sum of lines 22	and 23] (see	704, 404	27. 00
	Direct graduate medical education payments (from Wkst. E-4, line 50	0)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			o	29.00
30. 00	Subtotal (sum of lines 27 through 29)			704, 404	30.00
	Primary payer payments			197	1
	Subtotal (line 30 minus line 31)			704, 207	32. 00
-	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			1 0	33. 00
	Allowable bad debts (see instructions)			6, 664	
	Adjusted reimbursable bad debts (see instructions)			4, 332	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)		0	36.00
	Subtotal (see instructions)			708, 539	
	MSP-LCC reconciliation amount from PS&R			0	
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00 39. 50
1	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	
1	Partial or full credits received from manufacturers for replaced de	evices (see instruc	tions)		1
1	RECOVERY OF ACCELERATED DEPRECIATION	(,	0	1
40. 00	Subtotal (see instructions)			708, 539	40.00
	Sequestration adjustment (see instructions)			0	•
1	Demonstration payment adjustment amount after sequestration			0	
1	Sequestration adjustment-PARHM pass-throughs			702 040	40. 03
	Interim payments Interim payments-PARHM			703, 960	41.00
1	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only)				42. 01
	Balance due provider/program (see instructions)			4, 579	
	Balance due provider/program-PARHM (see instructions)				43. 01
	Protested amounts (nonallowable cost report items) in accordance wi	rth CMS Pub. 15-2, o	chapter 1,	0	44.00
H	§115.2 TO BE COMPLETED BY CONTRACTOR				-
1				0	90.00
90. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			o o	91.00
90. 00 91. 00 92. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	92.00
90. 00 91. 00 92. 00 93. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0 0.00 0	92.00

| Peri od: | Worksheet E-1 | From 03/24/2021 | Part I | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0191

				10 12/31/2021	5/31/2022 2: 38	
		Title XVIII		Hospi tal	PPS	
		Inpatier	Inpatient Part A		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		254, 23	2	703, 960	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER		I	0	1 0	3. 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		1	0		3. 01
			1			
3. 03			1	0		3. 03
3. 04 3. 05				0	0 0	3. 04
3.05	Provider to Program			U	U	3. 05
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ADJUSTIMENTS TO TROOKAM			0		3. 51
3. 52			1	0		3. 52
3. 53			1	Ö		3. 53
3. 54			l .	Ö	l ő	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		l .	0	0	3. 99
0. , ,	3. 50-3. 98)					0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		254, 23	2	703, 960	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)					
F 04	Program to Provider		1			F 04
5. 01	TENTATI VE TO PROVI DER		l .	0	0 0	5. 01
5. 02 5. 03				0		5. 02 5. 03
5.03	Provider to Program			U _I	U	5. 03
5. 50	TENTATI VE TO PROGRAM		1	o	1 0	5. 50
5. 51	TENTATI VE TO TROOKAWI		1	Ö		5. 51
5. 52			1	Ö	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1	0	0	5. 99
0. , ,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		121, 16	3	4, 579	6. 01
6.02	SETTLEMENT TO PROGRAM		1	0	0	6. 02
7.00	Total Medicare program liability (see instructions)		375, 39	5	708, 539	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se		0	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems FRANCISCAN BEACO	N HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCU	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0191 Period: From 03/24/2021				
			To 12/31/2021	Date/Time Pre 5/31/2022 2:3	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	The same of the sa	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 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	Peri od: From 03/24/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2022 2:38 pm
	T		<u> </u>

			10 12/31/2021	5/31/2022 2: 3	
		Title XIX	Hospi tal	Cost	<u> </u>
			I npati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		2, 362		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		2, 362	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2, 362	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9.00	Ancillary service charges		0	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	12. 00
40.00	CUSTOMARY CHARGES	<u>.</u>			40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for compless on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		٩	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		0.000000	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete onl	vifline 16 exceeds	o	0	1
	line 4) (see instructions)	ye ie execue		ŭ	
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	2, 362	0	18. 00
	16) (see instructions)	,			
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	, ,		0	0	
	Outlier payments		0	0	
24. 00			0		24. 00
	Capital exception payments (see instructions)		0	_	25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	29. 00
30. 00	Excess of reasonable cost (from line 18)		2, 362	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2, 302	0	
32. 00	Deductibles		0	0	
33. 00			0	0	
	Allowable bad debts (see instructions)		o o	0	
35. 00	Utilization review		o	Ü	35. 00
36. 00		1 33)	o	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	o	0	1
	Subtotal (line 36 ± line 37)		o	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		0	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				I

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

Provi der CCN: 15-0191 | Peri od: | From 03/24/2021 | To 12/31/2021 |

Date/Time Prepared: 5/31/2022 2:38 pm

OH y)					5/31/2022 2: 3	8 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2. 00	3. 00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3, 230, 138	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	6, 774, 147	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-4, 624, 662	0	0	0	6. 00
7.00	Inventory	161, 048	0	0	0	7. 00
8.00	Prepai d expenses	90, 653	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	5, 631, 324	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	1, 514, 351	0	0	0	12.00
13.00	Land improvements	42, 865	0	0	0	13.00
14.00	Accumul ated depreciation	-6, 430	0	0	0	14. 00
15.00	Bui I di ngs	18, 857, 743	0	0	0	15. 00
16.00	Accumul ated depreciation	-742, 246	0	0	0	16. 00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20. 00
21.00	Automobiles and trucks	0	0	o	0	21. 00
22.00	Accumul ated depreciation	0	0	o	0	22. 00
23.00	Major movable equipment	4, 628, 744	0	ol	0	23. 00
24.00	Accumul ated depreciation	-1, 233, 123		ol	ol	24. 00
25. 00	Mi nor equi pment depreci abl e	0		ol	0	25. 00
26. 00	Accumulated depreciation	0	0	ol	0	26. 00
27. 00	HIT designated Assets	0	0	ol	0	27. 00
28. 00	Accumulated depreciation	0	0	o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	Ō	ol	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	23, 061, 904		ol	0	30. 00
00.00	OTHER ASSETS	20/001/701		٥,	J	00.00
31. 00	Investments	0	0	0	0	31. 00
32. 00	Deposits on Leases	0		o	0	32. 00
33. 00	Due from owners/officers	0	0	Ö	0	33. 00
34. 00	Other assets	0	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	0		Ö	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	28, 693, 228		ol	0	36.00
30. 00	CURRENT LIABILITIES	20, 073, 220		<u> </u>		30.00
37. 00	Accounts payable	348, 205	0	ol	0	37. 00
38. 00	Salaries, wages, and fees payable	0 10, 200	ő	ol	0	38. 00
39. 00	Payroll taxes payable	0	j o	Ö	0	39. 00
40. 00	Notes and Loans payable (short term)		0	0	0	40.00
41. 00	Deferred income		0	0	Ö	41. 00
42. 00	Accel erated payments	0		٩	١	42. 00
43. 00	Due to other funds	10, 779, 833	0	٥	o	43. 00
44. 00	Other current liabilities	0,777,033		ol	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 128, 038		-		
45.00	LONG TERM LIABILITIES	11, 120, 030	0	<u> </u>		45.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	0		ő	0	
48. 00	Unsecured Loans	0		ő	0	48. 00
49. 00	Other long term liabilities	٥		Ö	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)			o	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11, 128, 038	_	ő	Ö	51.00
31.00	CAPITAL ACCOUNTS	11, 120, 030	U	<u> </u>	0	31.00
52. 00	General fund balance	17, 565, 190				52. 00
53. 00	Specific purpose fund	17, 303, 170	0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - restricted			o		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
				Ч	0	57.00
57.00	Plant fund balance - invested in plant				0	58.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				υļ	JO. UU
59. 00	Total fund balances (sum of lines 52 thru 58)	17, 565, 190	0	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	28, 693, 228		0	0	
50.00	[59]	20, 073, 220		٩	١	33.00
	1 /	1	1	'		•

Provider CCN: 15-0191

					To 12/31/2021	Date/Time Pre 5/31/2022 2:3	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	у ріп
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	0 0 0 0 0	20, 845, 484 -3, 280, 294 17, 565, 190		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	17, 565, 190 0 17, 565, 190		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

			T	o 12/31/2021	Date/Time Prep 5/31/2022 2:38	
	Cost Center Description	Li	npati ent	Outpati ent	Total	Э ріп
	obst denter becompared.		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		497, 942		497, 942	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		C		0	5. 00
6.00	Swing bed - NF		Č		0	6. 00
7. 00	SKILLED NURSING FACILITY		_		-	7. 00
8.00	NURSI NG FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		497, 942		497, 942	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	ines	C		0	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		497, 942		497, 942	17.00
18.00	Ancillary services		1, 014, 638	15, 714, 950	16, 729, 588	18.00
19.00	Outpati ent servi ces		142, 296	5, 594, 344	5, 736, 640	19.00
20.00	RURAL HEALTH CLINIC		C	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		C	0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)		C	0	0	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	1, 654, 876	21, 309, 294	22, 964, 170	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			7, 826, 426		29. 00
30.00	ADD (SPECIFY)		C			30.00
31. 00			C			31. 00
32. 00			C			32. 00
33. 00			C			33.00
34. 00			C			34.00
35. 00			C			35. 00
36. 00	Total additions (sum of lines 30-35)		_	0		36. 00
37. 00	DEDUCT (SPECIFY)		C			37. 00
38. 00			C			38. 00
39. 00			C			39. 00
40.00			C			40.00
41.00	T		C	_		41. 00
42. 00	Total deductions (sum of lines 37-41)			7 00/ 40/		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		7, 826, 426		43.00
	to Wkst. G-3, line 4)	l l				

Heal th	Financial Systems FRANCISCAN BEA	ACON HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0191	Peri od:	Worksheet G-3	
			From 03/24/2021 To 12/31/2021	Date/Time Prep 5/31/2022 2:38	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			22, 964, 170	
2.00	Less contractual allowances and discounts on patients' acc	ounts		18, 427, 980	
3.00	Net patient revenues (line 1 minus line 2)			4, 536, 190	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		7, 826, 426	
5.00	Net income from service to patients (line 3 minus line 4)			-3, 290, 236	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 communicat	I on services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			4, 045	
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters				15.00
16.00	Revenue from sale of medical and surgical supplies to othe	r than patients			16. 00
17. 00	Revenue from sale of drugs to other than patients			-	17. 00
18.00	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)				
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER INCOME			5, 897	
24. 50	COVI D-19 PHE Fundi ng			0	
	Total other income (sum of lines 6-24)				25. 00
	Total (line 5 plus line 25)			-3, 280, 294	
27. 00	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)		-3, 280, 294	29. 00

Hool +b	Financial Systems FRANCISCAN BEAC	NON HOSDITAL	In Lie	u of Form CMS-2	DEE2 10
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0191	Peri od: From 03/24/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/31/2022 2:3	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			0	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01 2. 00
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			0	2.00
3. 00	Total inpatient days divided by number of days in the cost i	caparting pariod (see inst	ructions)	0.00	
4. 00	Number of interns & residents (see instructions)	eportring perrod (see riis)	i uctions)	0.00	4. 00
5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the	ne 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 30) (see instructions)	patient days (Worksheet E	, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8. 00
9.00	Sum of lines 7 and 8			0.00	9. 00
10.00	Allowable disproportionate share percentage (see instruction	ns)			10. 00
11. 00	Disproportionate share adjustment (see instructions)			0	
12. 00	Total prospective capital payments (see instructions)			0	12. 00
	DART LL DAVMENT UNDER DEACONARIE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			141, 470	1. 00
2. 00	Program inpatient ancillary capital cost (see instructions)			25, 690	
3.00	Total inpatient program capital cost (line 1 plus line 2)			167, 160	
4. 00	Capital cost payment factor (see instructions)			85	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			142, 086	
				·	
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstan	nces (see instructions)		0	2.00
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0 0. 00	3. 00 4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinar		(line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	y crrediistances (Tric 2)	t title 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	
10.00	Current year comparison of capital minimum payment level to		less line 9)	0	
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	1 1 3 1	,	0	11. 00
12.00	Net comparison of capital minimum payment level to capital	payments (line 10 plus lin	ne 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positive, ento		0	13. 00	
14.00	Carryover of accumulated capital minimum payment level over			0	14. 00
	(if line 12 is negative, enter the amount on this line)		- •		
15. 00	Current year allowable operating and capital payment (see in	nstructions)		0	
16.00	1			0	
17.00	Current year exception offset amount (see instructions)			0	17. 00