This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0191 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/24/2024 10:48 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/24/2024 Time: 10:48 am use only ] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9. (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 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Am	y Herron	l 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				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	4, 911	12, 709	0	13, 239	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	4, 911	12, 709	0	13, 239	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

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

Health FinancialSystemsFRANCISCANBEACONHOSPITALIn Lieu of Form CMS-2552-10HOSPITALAND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATAProvider CCN: 15-0191Period: Worksheet S-2

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 10:48 am 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, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN BEACON 150191 33140 03/24/2021 Ν 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N 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.

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

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

58.00

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0191 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 10: 48 am XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

Health Financial Systems	FRANCI SO	CAN BEACON HOSPITA	L	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi der	1	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Pre 5/24/2024 10:4	pared:
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after J			sThis base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column)	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained resident n-primary care all nonprovider d non-primary care n column 3 the rati		0.00	0. 000000	64. 00
jot (cordini) i di vi ded by (cordini)	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0. C	Unweighted	0.000000 Ratio (col. 1/	65. 00
			FTEs Nonprovi der Si te	FTES in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Current	Vear FTE Residents in	n Nonnrovider Sott	1.00	2.00	3.00	
beginning on or after July 1, 20		T Nonprovider Sett	ingsLirective i	- Cost reporti	rig per rous	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.0	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
47 00 lp 4	1.00	2.00	3.00	4.00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.0	O. OC	0. 000000	67.00

117. 00

118. 00

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

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

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

Health Financial Systems FRANCISCAN BEAC	ON HOSPITAL		In Lie	u of Form CN	/S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 15-0191	Peri od: From 01/01/2023 To 12/31/2023	Worksheet : Part I Date/Time	S-2
		Dramiuma	Lange	5/24/2024	10: 48 am
		Premi ums	Losses	Insurance	
		1.00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00	2.00	3.00	0118.01
The engine of many doct of promitting and part recess.		1			0110101
110 02 Are melaportice premiume and sold League reported in a cost		than tha	1. 00 N	2. 00	110.00
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			IN.		118. 02
119.00 DO NOT USE THIS LINE 120.00 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 qualified Harmless provision in ACA §3121 and applicable amendments	column 1, "Y' alifies for th	" for yes or he Outpatient		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impla	ntable devices	s charged to	N		121. 00
patients? Enter "Y" for yes or "N" for no.		Ü			
122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 00
123.00 Did the facility and/or its subproviders (if applicable) pure			Y	N	123. 00
services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organization	5. 1 5				
for yes or "N" for no.					
If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from u					
located in a CBSA outside of the main hospital CBSA? In colu			-		
"N" for no.  Certified Transplant Center Information					
125.00 Does this facility operate a Medicare-certified transplant co	enter? Enter '	"Y" for yes	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/y		: 6:+:			127, 00
126.00  f this is a Medicare-certified kidney transplant program, elin column 1 and termination date, if applicable, in column 2.		irication dat	.e		126. 00
127.00 If this is a Medicare-certified heart transplant program, en	ter the certif	fication date	<b>;</b>		127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, en		fication date	ż		128. 00
in column 1 and termination date, if applicable, in column 2.					
129.00 If this is a Medicare-certified lung transplant program, ento in column 1 and termination date, if applicable, in column 2.	er the certifi	ication date			129. 00
130.00 If this is a Medicare-certified pancreas transplant program,		rti fi cati on			130. 00
date in column 1 and termination date, if applicable, in colu					121 00
131.00  f this is a Medicare-certified intestinal transplant program date in column 1 and termination date, if applicable, in column 1	m, enter the d umn 2.	certification	1		131. 00
132.00 If this is a Medicare-certified islet transplant program, en	ter the certif	fication date	<b>;</b>		132. 00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved					133. 00
134.00 If this is a hospital-based organ procurement organization (	OPO), enter th	he OPO number	-		134. 00
in column 1 and termination date, if applicable, in column 2.  All Providers					
140.00 Are there any related organization or home office costs as de	efined in CMS	Pub. 15-1,	N		140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If			6		
are claimed, enter in column 2 the home office chain number.  1.00 2.00		tions)	3.00		
If this facility is part of a chain organization, enter on I	ines 141 thro	0		of the	
home office and enter the home office contractor name and co 141.00 Name: Contractor's Name:	ntractor numbe		or's Number:		141. 00
142. 00 Street: P0 Box:		Joontract	or 3 Namber.		142. 00
143. 00 Ci ty:   State:		Zi p Code	):		143. 00
				1.00	
144.00 Are provider based physicians' costs included in Worksheet A	?			Y	144. 00
			1.00	2.00	
145.00  f costs for renal services are claimed on Wkst. A, line 74,	are the costs	s for	1. 00	2.00	145. 00
inpatient services only? Enter "Y" for yes or "N" for no in one, does the dialysis facility include Medicare utilization	column 1. If o	column 1 is			
period? Enter "Y" for yes or "N" for no in column 2.  146.00 Has the cost allocation methodology changed from the previous	sly filed cost	t report?	N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1					
yes, enter the approval date (mm/dd/yyyy) in column 2.					

Health Financial Systems	FRANCISCAN BEA			T		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	:N: 15-0191		: 1/01/2023 2/31/2023	Worksheet S Part I Date/Time P 5/24/2024 1	repared:
						1.00	_
147.00 Was there a change in the statisti	cal basis? Enter "V" for	voc or "N" for	20			1.00 N	147. 00
148.00 Was there a change in the statisti						N N	147. 00
149.00 Was there a change to the simplifi				or no		N N	149. 00
147. 00 was there a change to the shiphin	ed cost finding method: E	Part A	Part B		itle V	Title XIX	147.00
		1.00	2.00	<u> </u>	3.00	4.00	
Does this facility contain a provi		exemption from	n the appli		f the lowe	er of costs	
or charges? Enter "Y" for yes or '	N TOT HO FOR Each compon	N N	and Part E	3. (See 4 <sub>2</sub>	2 CFR 9413 N	N N	155. 00
156. 00 Subprovi der – TPF		N N	N N		N	N N	156. 0
157. 00 Subprovi der – I RF		N N	N N		N	N N	157. 0
158. 00 SUBPROVI DER							158. 0
159. 00 SNF		N	N		N	l N	159. 00
160.00 HOME HEALTH AGENCY		N	N N		N	N N	160. 00
161. 00 CMHC			N		N	N	161. 00
Multicampus						1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more campu	ses in dif	ferent CE	BSAs?	N	165. 00
,=,=,,	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. 0
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI				nent Act		1	
167.00 s this provider a meaningful user						Y	167. 00
168.00 If this provider is a CAH (line 10			e 16/ IS "Y	"), enter	the		168. 0
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r			aualify f	or a bara	lchi n	•	168. 0
exception under §413.70(a)(6)(ii)?					isni þ		108.0
169.00 If this provider is a meaningful u					enter the	0	00169. 0
transition factor. (see instruction		10 1101 4 0111 (		0 ,, 0			
				Ве	gi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporting				170. 00
					1 00	2.00	
171 00 lf line 147 is "V" does this	il don have any days for in	di vi dual a ancel	Lod in		1. 00 N	2.00	0171 0
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans roughly "Y" for yes and "N" for no in colu	reported on Wkst. S-3, Pt.	I, line 2, col	. 6? Enter		IN		0 171. 00

Heal th	Financial Systems FRANCISCAN BEA	ACON HOSPITAL		In lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0191	Period: From 01/01/2023	Worksheet S-2 Part II	
				To 12/31/2023	Date/Time Pre 5/24/2024 10:	
				Y/N 1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	EMENT QUESTIONN	IAI RE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format.	l for all NO re	esponses. Ente	er all dates in <sup>.</sup>	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					1
1.00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in a	corumn 2. (see	Y/N	Date	V/I	
0.00	In the second	2 0 1 6	1.00	2. 00	3.00	0.00
2. 00	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. 00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)			3. 00		
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" 1 or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	N			4. 00
5.00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differenthose on the filed financial statements?		N			5. 00
	those on the fired financial statements: If yes, submit fee	CONCLETE ALL OIL		Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, is	the provide	n N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	e N		7. 00 8. 00
9.00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or coinsuratinstructions.	ance amounts wa	nived? If yes,	see	N	14. 00
15. 00	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	yes, see ins	tructions.	N	15. 00
			t A		t B	
		1. 00	2. 00	Y/N 3. 00	Date 4.00	
1	PS&R Data					1
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y	04/01/2024	Y	04/01/2024	16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems FRANCISCAN BE.	ACON HOSPITAL		In Lie	u of Form CN	IS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0191	Period: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/24/2024 1	Prepared:				
			iption	Y/N	Y/N					
	1011 11 12 13 13 13 13 13 13 13 13 13 13 13 13 13		0	1. 00	3. 00	22.22				
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00				
	Thopas is data for other bookings the other day dother to	Y/N	Date	Y/N	Date					
		1.00	2.00	3. 00	4. 00					
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00				
					1. 00					
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	HOSPI TALS)		1.00					
	Capital Related Cost									
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense		sals made du	ring the cost		22. 00 23. 00				
0.4.00	reporting period? If yes, see instructions.									
24. 00	If yes, see instructions									
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period	! If yes, see		25. 00				
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	he cost reporti	ng period?	lf yes, see		26. 00				
27. 00	Has the provider's capitalization policy changed during th	e cost reportir	ng period? I	f yes, submit		27. 00				
	copy. Interest Expense									
28. 00	Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cos	t reporting		28. 00				
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service I	Reserve Fund)		29. 00				
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes	s, see		30.00				
	instructions.	,	,							
31. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	s, see		31.00				
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	rvices furnish	ed through co	ontractual		32. 00				
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competi	tive biddina? If		33. 00				
	no, see instructions.		J							
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an	arrangomont wit	th provider l	pacod phyci ci anc?		34.00				
34.00	If yes, see instructions.	arrangement wi	tii provider-i	based physicians:		34.00				
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based		35. 00				
				Y/N	Date					
	Home Offi on Conta			1. 00	2. 00					
36. 00	Home Office Costs Were home office costs claimed on the cost report?					36.00				
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office	?		37. 00				
38. 00	If line 36 is yes , was the fiscal year end of the home of			f		38. 00				
39. 00	j			5,		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				
	THISTI GOTI OHS.									
	Cost Penort Preparer Contact Information	1.	00	2.	00					
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA SEVERS				41. 00				
42. 00	respectively.  Enter the employer/company name of the cost report	BLUE & CO. , LLC								
	preparer.		_0			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 Fi	nancial Systems	FRANCI SCAN	BEACON	HOSPI TAL			In Lie	u of Form CMS	-2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN:	Perion From To	od: 01/01/2023 12/31/2023	Date/Time Pr	epared:
								5/24/2024 10	:48 am
				;	3.00				
Cos	st Report Preparer Contact Information								
41. 00 En	nter the first name, last name and the t	itle/position	MAN	IAGER					41. 00
he	eld by the cost report preparer in colum	ns 1, 2, and 3,							
re	especti vel y.								
42. 00 En	nter the employer/company name of the co	st report							42. 00
pr	reparer.								
43. 00 En	nter the telephone number and email addr	ess of the cost	t						43.00
re	eport preparer in columns 1 and 2, respe	cti vel y.							

				'	12/31/2023	5/24/2024 10:4	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	8	2, 920	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					ol	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					l ol	6.00
7. 00	Total Adults and Peds. (exclude observation		8	2, 920	0.00	0	7. 00
	beds) (see instructions)			_,			
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)		8	2, 920	0.00	o	14. 00
15. 00	CAH visits			2, ,20	0.00	o o	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVI DER - I PF				0.00	o l	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	HOSPICE						24. 00
24. 00	HOSPICE (non-distinct part)	30. 00					24. 00
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25		89. 00				0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	8	,		U	26. 25 27. 00
	Total (sum of lines 14-26)		٥			o	
28. 00 29. 00	Observation Bed Days					U	28. 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)		0	)	ן		32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges	00.00	_	,			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	)  (	기	0	34. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/24/2024	10: 48 am

						5/24/2024 10:	48 am
		I/P Days	3 / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	10	1	15			1. 00
2.00	HMO and other (see instructions)	ol	0				2.00
3.00	HMO IPF Subprovider	o	0				3. 00
4.00	HMO IRF Subprovider	ol	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	C	)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C	)		6. 00
7. 00	Total Adults and Peds. (exclude observation	10	1	15			7. 00
0.00	beds) (see instructions)						0.00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
10.00	CORONARY CARE UNIT						10.00
11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						11.00
12.00	1						12.00
13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						13.00
14. 00	Total (see instructions)	10	1	15	0.00	33. 65	
15. 00	CAH visits	0	0			33.03	15. 00
15. 10	REH hours and visits	٥	0	l o			15. 10
16. 00	SUBPROVI DER - I PF	Ĭ	O	Ĭ			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)			C	)		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0.00	33. 65	
28. 00	Observation Bed Days		0	21			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			C			30. 00
31. 00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	0	0	C			32.00
32. 01	Total ancillary labor & delivery room				'		32. 01
22 00	outpatient days (see instructions)						22.00
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01
	Temporary Expansion COVID-19 PHE Acute Care	0	0	C			34.00
34.00	Tremporary Expansion Covid-19 File Acute Care	ı Y	U	1	1	I	J 34. 00

				10	0 12/31/2023	5/24/2024 10:	
		Full Time		Di sch	arges	0,21,2021 101	10 (111)
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	7	1	10	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			0	0		2. 00
3.00	HMO IPF Subprovider				0		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
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT						11. 00 12. 00
12.00	OTHER SPECIAL CARE (SPECIFY) NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	7	1	10	•
15. 00	CAH visits	0.00	0	1	!	10	15. 00
15. 10	REH hours and visits						15. 10
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	ŀ					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
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0191

					T	o 12/31/2023	Date/Time Prep 5/24/2024 10:4	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	70 aiii
		Number	Reported	on of Salaries (from Wkst.	Sal ari es $(col. 2 \pm col.$	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	, i	
	PART II - WAGE DATA	1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see	200. 00	3, 242, 735	0	3, 242, 735	70, 002. 00	46. 32	1. 00
2. 00	instructions) Non-physician anesthetist Part		C	0	0	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part B		C	0	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		0	0	0	0. 00 0. 00	1	1
6.00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	O	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		C	O	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	O	0	0.00	0. 00	8. 00
9. 00	SNF	44. 00	C	o	0	0.00	0.00	9. 00
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		C	0	0	0.00	0.00	10. 00
11. 00	Contract labor: Direct Patient Care		250, 784	0	250, 784	4, 185. 00	59. 92	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		C	O	0	0.00	0.00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		C	0	0	0. 00	0.00	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		C	o o	0	0.00	0. 00	14. 00
14. 01	Home office salaries		C	o	0	0.00	1	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0	0	0. 00 0. 00	1	14. 02 15. 00
13.00	- Administrative				O	0.00	0.00	13.00
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	O	0	0. 00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	0	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see		613, 627	0	613, 627			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		0	0	0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
22. 00	B Physician Part A -		C	O	0			22. 00
22. 01	Administrative Physician Part A - Teaching		C	0	0			22. 01
23.00	Physician Part B		C	o	0			23. 00
24. 00 25. 00	Interns & residents (in an		0	1	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		C	0	0			25. 50
25. 51	(core) Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		C	0	0			25. 52
	wage-rel ated (core)							l

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0191

						3 12/31/2023	5/24/2024 10:	48 am
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		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)							
04 00	OVERHEAD COSTS - DIRECT SALARII					0.00	0.00	0, 00
26. 00	Employee Benefits Department	4. 00	057.004	0	0 0 7 7 5	0.00		
27. 00	Administrative & General	5. 00	357, 234		368, 675	12, 180. 00		
28. 00	Administrative & General under		8, 750	0	8, 750	19. 00	460. 53	28.00
29. 00	contract (see inst.)	4 00	0			0.00	0.00	29. 00
30.00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	0		0	0.00		
31. 00		8. 00	0		0	0.00		
31.00	Laundry & Linen Service Housekeeping	9.00	0	0	0	0.00		
33. 00	Housekeeping under contract	9.00	0		0	0.00		33.00
33.00	(see instructions)		U	0	U	0.00	0.00	33.00
34. 00	Di etary	10. 00	0	0	0	0.00	0.00	34. 00
35. 00	Dietary under contract (see	10.00	0		0	0.00	l .	
33.00	instructions)		0		O	0.00	0.00	33.00
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		
38. 00	Nursing Administration	13. 00	0	0	0	0.00		38. 00
39. 00	Central Services and Supply	14. 00	0	0	0	0. 00		39. 00
40. 00	Pharmacy	15. 00	0	0	0	0.00		40. 00
41. 00	Medical Records & Medical	16. 00	0	0	0	0.00		
	Records Library		_					
42.00	Soci al Servi ce	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

	AE MAGE TROCK THE GRAMMET ON			Trovider ox		From 01/01/2023 To 12/31/2023		
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		3, 251, 485	0	3, 251, 48	5 70, 021. 00	46. 44	1.00
	instructions)							
2.00	Excluded area salaries (see		0	0		0.00	0.00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		3, 251, 485	0	3, 251, 48	5 70, 021. 00	46. 44	3.00
	minus line 2)							
4.00	Subtotal other wages & related		250, 784	0	250, 78	4, 185. 00	59. 92	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		613, 627	0	613, 62	7 0.00	18. 87	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		4, 115, 896	0	4, 115, 89	6 74, 206. 00	55. 47	6.00
7.00	Total overhead cost (see		365, 984	11, 441	377, 42	5 12, 199. 00	30. 94	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	Period: Worksheet S-3 From 01/01/2023 Part IV	
		To 12/31/2023 Date/Time Prepared:	

	To 12/31/2023	B Date/Time Pre 5/24/2024 10:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	111, 960	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)	271, 034	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	2, 795	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	1, 895	11. 00
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	5, 046	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
	Noncumulative portion)		
	TAXES		
	FICA-Employers Portion Only	219, 586	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	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	9 0	21. 00
	<pre>instructions))</pre>		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	1, 311	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	613, 627	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-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0191	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/24/2024 10:48 am
	· ·		B 61 + 0 +

		'	0 12/31/2023	5/24/2024 10:	
	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		250, 784	613, 627	1. 00
2.00	Hospi tal		250, 784	613, 627	2. 00
3.00	SUBPROVI DER - I PF				3. 00
4.00	SUBPROVI DER - I RF				4. 00
5.00	Subprovi der - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	SKILLED NURSING FACILITY				8. 00
9.00	NURSING FACILITY				9. 00
10.00	OTHER LONG TERM CARE I				10. 00
11. 00	Hospi tal -Based HHA				11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P. ) I				12.00
13.00	Hospi tal -Based Hospi ce				13. 00
14.00	Hospital-Based Health Clinic RHC				14. 00
15. 00	Hospital-Based Health Clinic FQHC				15. 00
16. 00	Hospi tal -Based-CMHC				16. 00
17. 00	RENAL DIALYSIS I		0	0	17. 00
18. 00	Other		0	0	18. 00

Uoal +h	ı Financial Systems FRANCISCAN BEACON H	OSDI TAI		In lic	eu of Form CMS-2	2552 10
	3	rovider CCN:	F	Period: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II	0 pared:
					1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1
1.00	Cost to charge ratio (see instructions)				0. 264272	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				6, 491	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?			10		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	1 2	rom Medicai	ď?		4. 00
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments fro Medicaid charges	m wedicald			0 19, 730	5. 00 6. 00
7. 00	Medicaid cost (line 1 times line 6)				5, 214	
8. 00	Difference between net revenue and costs for Medicaid program (s	ee instructi	ons)		0,214	
0.00	Children's Health Insurance Program (CHIP) (see instructions for		0.10)			0.00
9.00	Net revenue from stand-alone CHIP	,			0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (s				0	12. 00
	Other state or local government indigent care program (see instr					
13.00	Net revenue from state or local indigent care program (Not inclu				0	
14.00	14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or					
15. 00	10)   State or local indigent care program cost (line 1 times line 14)				0	15. 00
16. 00	Difference between net revenue and costs for state or local indi		ogram (see	instructions)	Ö	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)				ns (see	
17. 00	Private grants, donations, or endowment income restricted to fun	ding charity	care		0	17. 00
18.00	Government grants, appropriations or transfers for support of ho	spital opera	tions		0	18. 00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local	indigent car	e programs	(sum of lines	0	19. 00
	8, 12 and 16)	I	Uni nsured	Insured	Total (col. 1	
			pati ents	patients	+ col . 2)	
			1. 00	2. 00	3.00	
	Uncompensated care cost (see instructions for each line)	<u> </u>				
20. 00	Charity care charges and uninsured discounts (see instructions)		(	., ,		1
21. 00	Cost of patients approved for charity care and uninsured discoun	ts (see	(	1, 541, 837	1, 541, 837	21. 00
22.00	instructions)	££				22.00
22. 00	Payments received from patients for amounts previously written o charity care	orr as	(	0	0	22. 00
23. 00	Cost of charity care (see instructions)		(	1, 541, 837	1, 541, 837	23. 00
24.00	Door the amount on line 20 cel. 2 include charges for notices d	lavia haviand a	langth of	atau limit	1. 00 N	24. 00
24. 00	Does the amount on line 20 col. 2, include charges for patient d imposed on patients covered by Medicaid or other indigent care p		rength of	Stay TIMIT	IN IN	24.00
25. 00			re program'	s Lenath of	0	25. 00
23.00	stay limit	a. goire ou	5 p. 591 am	g : 11 01		
25. 01					0	
26 00	Bad debt amount (see instructions)				27 873	26 00

26.00

27. 01

28.00

29.00

30.00

27, 873 18, 117

27, 873

9, 756

1, 551, 593 31. 00

1, 551, 593

Bad debt amount (see instructions)

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

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

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

SPI TA	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0191	Peri od: From 01/01/2023 To 12/31/2023		epar			
				1. 00				
	PART II - HOSPITAL DATA							
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
	Cost to charge ratio (see instructions)			0. 264272	2			
- +	Medicaid (see instructions for each line)			I				
	Net revenue from Medicaid							
	Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?							
	If line 4 is no, then enter DSH and/or supplemental payments f		Cal u?					
	Medicaid charges	Tolli Medicald			ł			
	Medicaid cost (line 1 times line 6)				ŀ			
- 1	Difference between net revenue and costs for Medicaid program							
+	Children's Health Insurance Program (CHIP) (see instructions f			l				
	Net revenue from stand-alone CHIP	,						
. 00	Stand-alone CHIP charges				1			
00	Stand-alone CHIP cost (line 1 times line 10)				1			
	Difference between net revenue and costs for stand-alone CHIP (see instructions)							
	Other state or local government indigent care program (see ins				1			
00	Charges for patients covered under state or local indigent car	e program (Not include	ed in lines 6 or		1			
00	10)	4)			1			
	0   State or local indigent care program cost (line 1 times line 14) 0   Difference between net revenue and costs for state or local indigent care program (see instructions)							
	Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	instructions for each line)	ii and state/rocal file	ingent care program	113 (300				
	,							
. 00	Government grants, appropriations or transfers for support of	hospital operations			1			
. 00	Total unreimbursed cost for Medicaid, CHIP and state and loca	l indigent care progra	ams (sum of lines		1			
	8, 12 and 16)	1						
		Uni nsure		Total (col. 1				
		patients 1.00	s patients 2.00	+ col . 2) 3.00	+			
	Uncompensated care cost (see instructions for each line)	1.00	2.00	3.00				
	Charity care charges and uninsured discounts (see instructions	)	0 0	0	1 2			
	Cost of patients approved for charity care and uninsured disco	•	0 0	O	) 2			
	instructions)	`						
. 00	Payments received from patients for amounts previously written	off as	0 0	0	) 2			
	chari ty care				١.			
. 00	Cost of charity care (see instructions)		0 0	0	) 2			
				1.00	+			
00	Does the amount on line 20 col. 2, include charges for patient	days bayand a Langth	of stay limit	1. 00 N	2			
00	imposed on patients covered by Medicaid or other indigent care		or stay irillit	IN IN	^			
00	If line 24 is yes, enter the charges for patient days beyond t		ram's Length of	0	) 2			
	stay limit	a. go ca. c p. cg.	am o rongen or		_			
01	Charges for insured patients' liability (see instructions)			0	) 2			
	Bad debt amount (see instructions)			27, 873				
	Medicare reimbursable bad debts (see instructions)			18, 117				
1	Medicare allowable bad debts (see instructions)			27, 873				
00	Non-Medicare bad debt amount (see instructions)			0	) 2			
00	Cost of non-Medicare and non-reimbursable Medicare bad debt am	ounts (see instruction	ns)	9, 756	2			
	and the second of the second o			0 75/	3			
	Cost of uncompensated care (line 23, col. 3, plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus l			9, 756	ין י			

	oost center bescription	Sararres	other	+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 713, 361	1, 713, 361	0	1, 713, 361	1.00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	613, 627	613, 627	0	613, 627	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	357, 234	2, 251, 592	2, 608, 826	11, 441	2, 620, 267	5. 00
7.00	00700 OPERATION OF PLANT	0	720, 994	720, 994	0	720, 994	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	766	766	0	766	8. 00
9.00	00900 HOUSEKEEPI NG	0	2, 566	2, 566	0	2, 566	9. 00
10.00	01000 DI ETARY	0	612	612	0	612	10.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 885, 501	24, 075	2, 909, 576	-2, 884, 884	24, 692	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	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	23, 964	23, 964	1, 038, 366	1, 062, 330	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	000 000	000 000	0	0	59.00
60.00	06000 LABORATORY	0	990, 968	990, 968	0	990, 968	60.00
60. 01	06001 BLOOD LABORATORY	١	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0	0	0	0	63. 00 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	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY		0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		9, 744	9, 744	0	9, 744	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		7, 744	7, 744 O	0	0, 744	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	0	0	. 0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		165, 070	165, 070	1, 221	166, 291	73. 00
74. 00	07400 RENAL DIALYSIS	0	100, 070	00,070	1, 221	00,271	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	o	o	0	o	0	78. 00
	OUTPATIENT SERVICE COST CENTERS		-1	-	-1		
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
91.00	09100 EMERGENCY	O	1, 490, 509	1, 490, 509	1, 833, 856	3, 324, 365	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					i	92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		3, 242, 735	8, 007, 848	11, 250, 583	0	11, 250, 583	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0 007 010	0	0		193. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	3, 242, 735	8, 007, 848	11, 250, 583	0	11, 250, 583	J∠UU. UU

Peri od: Worksheet A From 01/01/2023 Date/Time Prepared: 5/24/2024 10:48 am

				5/24/2024 10	: 48 am
	Cost Center Description	Adjustments	Net Expenses		
	· ·		or Allocation		
		6.00	7. 00		
GE	ENERAL SERVICE COST CENTERS				
1.00 00	0100 CAP REL COSTS-BLDG & FIXT	0	1, 713, 361		1. 00
3.00 00	0300 OTHER CAP REL COSTS	o	0		3. 00
4.00 00	0400 EMPLOYEE BENEFITS DEPARTMENT	o	613, 627		4. 00
5.00 00	0500 ADMINISTRATIVE & GENERAL	-265, 658	2, 354, 609		5. 00
7.00 00	0700 OPERATION OF PLANT	ol	720, 994		7.00
	0800 LAUNDRY & LINEN SERVICE	o	766		8. 00
	0900 HOUSEKEEPI NG	o	2, 566		9. 00
	1000 DI ETARY	l ol	612		10.00
	NPATIENT ROUTINE SERVICE COST CENTERS	٩	0.2		1 .0.00
	3000 ADULTS & PEDIATRICS	O	24, 692		30.00
	NCILLARY SERVICE COST CENTERS	<u> </u>	21,072		- 00:00
	5000 OPERATING ROOM	ol	0		50.00
	5100 RECOVERY ROOM		0		51.00
	5200 DELIVERY ROOM & LABOR ROOM		0		52.00
	5300 ANESTHESI OLOGY		0		53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	1, 062, 330		54.00
	5500 RADI OLOGY-THERAPEUTI C	0	1,002,330		55. 00
		-1	0		56. 00
	5600 RADI OI SOTOPE	0	0		
	5700 CT SCAN	0	0		57. 00
	5800 MRI	0	0		58. 00
	5900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
	6000 LABORATORY	0	990, 968		60.00
	6001 BLOOD LABORATORY	0	0		60. 01
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61. 00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62. 00
	6300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
	6400 INTRAVENOUS THERAPY	0	0		64. 00
	6500 RESPI RATORY THERAPY	0	0		65. 00
	6600 PHYSI CAL THERAPY	0	0		66. 00
	6700 OCCUPATI ONAL THERAPY	0	0		67. 00
	6800 SPEECH PATHOLOGY	0	0		68. 00
	6900 ELECTROCARDI OLOGY	0	9, 744		69. 00
	7000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
72. 00   07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0	166, 291		73. 00
74.00 07	7400 RENAL DIALYSIS	0	0		74.00
75. 00 07	7500 ASC (NON-DISTINCT PART)	0	0		75. 00
77. 00 07	7700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00 07	7800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
OL	UTPATIENT SERVICE COST CENTERS				
90.00	9000 CLI NI C	0	0		90. 00
91.00 09	9100 EMERGENCY	-1, 390, 151	1, 934, 214		91. 00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
ΓO	THER REIMBURSABLE COST CENTERS				
	0200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
	PECIAL PURPOSE COST CENTERS	-1	-		
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 655, 809	9, 594, 774		118. 00
	ONREI MBURSABLE COST CENTERS	., 500, 007	., ., ., , , ,		1
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		190. 00
	9100 RESEARCH		0		191. 00
	9200 PHYSICIANS' PRIVATE OFFICES		0		192. 00
	9300 NONPALD WORKERS	ا	n		193. 00
200. 00	TOTAL (SUM OF LINES 118 through 199)	-1, 655, 809	9, 594, 774		200. 00
200.00	1.5 (Som Si Elites 116 till dagil 177)	1,000,007	7, 571, 774		1200.00

Heal th Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0191 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						10 1	2/31/2023	Date/ IT lie	
								5/24/2024	10:48 am_
		Increases							
	Cost Center	Li ne #	Sal ary	0ther					
	2. 00	3. 00	4. 00	5.00					
	A - SALARY RECLASS								
1.00	RADI OLOGY-DI AGNOSTI C	54.00	1, 038, 366	0					1. 00
2.00	DRUGS CHARGED TO PATIENTS	73. 00	1, 221	0					2. 00
3.00	EMERGENCY	91.00	1, 833, 856	0					3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	11, 441	0					4. 00
	TOTALS		2, 884, 884	0					
500.00	Grand Total: Increases		2, 884, 884	0					500.00

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

RECLASSIFICATIONS Provider CCN: 15-0191 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						10	12/31/2023   Date/IIMe I	
							5/24/2024	10:48 am
		Decreases						
	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, 884, 884	(	)	0		1. 00
2.00		0.00	0	C		0		2. 00
3.00		0.00	0	C		0		3. 00
4.00		0.00	0	C		0		4. 00
	TOTALS		2, 884, 884		)	7		1
500.00	Grand Total: Decreases		2, 884, 884	C	)			500. 00

					Го 12/31/2023	Date/Time Prep 5/24/2024 10:	oared: 48 am_
			Acqui si ti ons				
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 514, 351	0	(	0	0	1. 00
2.00	Land Improvements	42, 865	0	(	0	0	2. 00
3.00	Buildings and Fixtures	18, 535, 918	0		0	0	3. 00
4.00	Building Improvements	321, 825	0		0	0	4. 00
5.00	Fi xed Equi pment	3, 762, 178	0		0	0	5. 00
6.00	Movable Equipment	905, 250	0		0	3, 384	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	25, 082, 387	0		0	3, 384	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	25, 082, 387	0	(	0 0	3, 384	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	Fixed Equipment	3, 762, 178	0				5. 00
6.00	Movable Equipment	901, 866	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	25, 079, 003	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	25, 079, 003	0				10. 00

Health Financial Systems		FRANCISCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-0191	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II Date/Time Pre 5/24/2024 10:	pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 713, 361	0		0 0	0	1. 00
3.00	Total (sum of lines 1-2)	1, 713, 361	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 713, 361				1. 00
3. 00	Total (sum of lines 1-2)	0	1, 713, 361				3. 00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
			-	From 01/01/2023 To 12/31/2023	Part III   Date/Time Prep	pared.
				5/24/2024 10: 4		
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
cost center beserver on	01033 A33C13	Leases	for Ratio	instructions)	Trisul direc	
			(col. 1 - col.			
			2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FLXT	18, 535, 918	l e	18, 535, 918			1. 00
3.00 Total (sum of lines 1-2)	18, 535, 918		18, 535, 918			3. 00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	/ 00	d Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00 CAP REL COSTS-BLDG & FIXT	ENTERS			1, 713, 361	0	1. 00
3.00 Total (sum of lines 1-2)	0	0		1, 713, 361	0	3. 00
3.00   Total (Suill of Titles 1-2)	U	SI SI	JMMARY OF CAPI		U	3.00
		30	DIVINIARY OF CALL	IAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DART LLL DESCRIPTION OF CARLEY COOTS OF	11.00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS				1 710 0/1	
1.00 CAP REL COSTS-BLDG & FLXT	0	0	`	-	1, 713, 361	1.00
3.00  Total (sum of lines 1-2)	0	0	(	0	1, 713, 361	3. 00

12/31/2023 Date/Time Prepared: 5/24/2024 10:48 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL 1. 00 OCAP REL COSTS-BLDG & FIXT 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL 0 \*\*\* Cost Center Deleted \*\*\* 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 В -17 ADMINISTRATIVE & GENERAL 4 00 5 00 discounts (chapter 8) 5.00 Refunds and rebates of В -32 268 ADMINISTRATIVE & GENERAL 5.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -1, 390, 151 10.00 Provider-based physician A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 0 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests 0 0.00 14.00 15.00 15.00 Rental of quarters to employee 0.00 and others 0.00 16.00 16.00 Sale of medical and surgical supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 0 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 20.00 Vending machines 0.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 \*\*\* Cost Center Deleted \*\*\* 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL 0 \*\*\* Cost Center Deleted \*\*\* 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 \*\*\* Cost Center Deleted \*\*\* 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29.00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 32.00 0.00 Depreciation and Interest 33. 00 OTHER REVENUE -20 ADMINISTRATIVE & GENERAL В 5.00 0 33.00

Health Financial Systems			FRANCISCAN BEA	CON HOSPITAL	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES				Provider CCN: 15-0191	Peri od:	Worksheet A-8	
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/24/2024 10:	
				Expense Classification o	n Worksheet A	372472024 10.	40 aiii
				To/From Which the Amount is			
				To Troin will on the fundame to	to be majusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 01	HAF FEES	A	-205, 801	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	LOBBYING EXPENSE	A	-720	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	MARKETING EXPENSE	A	-26, 832	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
50.00	TOTAL (sum of lines 1 thru 49)		-1, 655, 809				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> 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 12/31/2023		
	Wkst. A Line #	Cost Center/Physician	Total	Profess	si onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Compo	nent	Component		ider Component	
						·		Hours	
	1. 00	2. 00	3. 00	4. (		5. 00	6. 00	7. 00	
1.00	91.00	EMERGENCY	1, 390, 151	1, 3	390, 151	C	211, 500	0	
2.00	0.00		0	)	0				
3.00	0.00		0	)	0	_	1	_	3. 00
4.00	0.00		0		0	C	0	0	4. 00
5.00	0.00		0		0	C	0	0	5. 00
6.00	0.00		0		0	C	0	0	6. 00
7.00	0.00		0		0	C	0	0	7. 00
8.00	0.00		0		0	C	0	0	8. 00
9.00	0.00		0		0	C	0	0	9. 00
10.00	0.00		0		0	C	0	0	10. 00
200.00			1, 390, 151		390, 151	C		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Perce		Cost of	Provi der	Physician Cost	
		Identifier	Limit			Memberships &	Component	of Malpractice	
				Lim	i t	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2. 00	8. 00	9. (		12. 00	13. 00	14. 00	
1.00		EMERGENCY	0	)	0	l -	1	_	
2.00	0. 00		0	)	0	l -	1		2. 00
3.00	0. 00		0	)	0	_		0	
4.00	0. 00		0	)	0	_	1	0	4. 00
5.00	0. 00		0	)	0	C		0	5. 00
6.00	0.00		0	)	0	C	0	0	6. 00
7.00	0. 00		0	)	0	C	0	0	
8.00	0. 00		0	9	0	C	0	0	8. 00
9.00	0.00		0	)	0	C	0		9. 00
10.00	0. 00		0	)	0	C	0	ľ	10. 00
200.00			0	)	0	C		0	200. 00
	Wkst. A Line #	,	Provi der	Adj uste		RCE	Adjustment		
		Identifier	Component	Lim	it	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		00				1. 00
2. 00	0.00				0	_			2. 00
3.00	0.00				0	_	-		3. 00
4. 00	0.00	l .			0	_	_		4. 00
5. 00	0.00				0		1		5. 00
6. 00	0.00				0	_			6. 00
7. 00	0.00				0				7. 00
8. 00	0.00				0	_	1		8. 00
9. 00	0.00				0		1		9.00
9. 00 10. 00	0.00	1			0	I -	1		10.00
200.00	0.00				0				200. 00
200.00	I	ļ	1	Ί	U	1	I, 390, 151	l	200. 00

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0191 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 10:48 am CAPI TAL RELATED COSTS ADMI NI STRATI VE Cost Center Description Net Expenses **EMPLOYEE** Subtotal BLDG & FIXT for Cost BENEFITS & GENERAL DEPARTMENT Allocation (from Wkst A col. 7) 1.00 4.00 5. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 713, 361 1 00 1, 713, 361 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 613, 627 613, 627 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 2, 354, 609 84, 349 69, 765 2, 508, 723 2, 508, 723 5.00 00700 OPERATION OF PLANT 720, 994 7 00 194, 066 O 915, 060 323, 965 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 766 31, 537 0 32, 303 11, 436 8.00 9.00 00900 HOUSEKEEPI NG 2,566 7, 302 0 9, 868 3, 494 9.00 <u>26, 5</u>01 27, 113 01000 DI ETARY 0 9, 599 10.00 10.00 612 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 24, 692 535, 870 117 560, 679 198, 501 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0 0 05100 RECOVERY ROOM 51.00 0 Ω 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 C 0 0 0 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 1,062,330 375, 354 54.00 196, 491 1, 634, 175 578, 558 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 C 0 55 00 56.00 05600 RADI OI SOTOPE 0 56.00 0 0 57.00 05700 CT SCAN 0 Ω 0 0 0 57.00 05800 MRI 0 58.00 0 0 58.00 C 0 05900 CARDIAC CATHETERIZATION 0 59.00 0 Λ 59.00 990, 968 06000 LABORATORY 0 1, 018, 224 360, 489 60.00 27, 256 60.00 06001 BLOOD LABORATORY 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 C 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 63.00 0 o 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0 06500 RESPIRATORY THERAPY 0 0 0 65.00 C 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 Ω 0 0 O 67.00 06800 SPEECH PATHOLOGY 0 68.00 Ω Λ 68.00 69. 00 06900 ELECTROCARDI OLOGY 9,744 19,640 29, 384 10, 403 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 0 0 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 Λ 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 166, 291 14, 289 231 180, 811 64,014 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 C 07500 ASC (NON-DISTINCT PART) 0 75 00 0 Ω 0 0 75 00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 C 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLINIC 0 0 91.00 09100 EMERGENCY 1, 934, 214 397, 197 347, 023 2, 678, 434 948, 264 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 508, 723 118. 00 9, 594, 774 1, 713, 361 613, 627 9, 594, 774 NONREI MBURSABLE COST CENTERS 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0

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0 201.00

2, 508, 723 202. 00

200.00

191. 00 19100 RESEARCH

200.00

201.00

202.00

193. 00 19300 NONPALD WORKERS

192.00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0191

				To	12/31/2023	Date/Time Pre 5/24/2024 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Subtotal	TO dill
	·	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	24. 00	
	GENERAL SERVICE COST CENTERS	T		T			
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	1, 239, 025					5. 00 7. 00
	00800 LAUNDRY & LINEN SERVICE	27, 231	70, 970				8. 00
	00900 HOUSEKEEPI NG	6, 305					9. 00
	01000 DI ETARY	22, 883	0		59, 968		10.00
	INPATIENT ROUTINE SERVICE COST CENTERS			2.3	217.122		
30. 00	03000 ADULTS & PEDIATRICS	462, 704	35, 485	7, 549	59, 968	1, 324, 886	30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	0	0	0	50.00
	05100 RECOVERY ROOM	0	0		0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
	05400 RADI OLOGY - DI AGNOSTI C	324, 105	0	5, 288	0	2, 542, 126	
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
	05600 RADI 0I S0T0PE 05700 CT SCAN	0	0	0	U	0	56.00
	05700 CT SCAN 05800 MRI	0	0	0	0	0	57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
	06000 LABORATORY	23, 535	0	384	ol Ol	1, 402, 632	60.00
	06001 BLOOD LABORATORY	0	0	0	ol	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_		آ	0	61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	o	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	o	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	o	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	16, 958	0	277	0	57, 022	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	07200 MPL. DEV. CHARGED TO PATIENTS	12 220	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	12, 338	0	201	U O	257, 364	73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	0	U O	0	74. 00 75. 00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	Ö	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		70.00
	09000 CLI NI C	0	0	0	0	0	90. 00
91. 00	09100 EMERGENCY	342, 966	35, 485	5, 595	o	4, 010, 744	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 239, 025	70, 970	19, 667	59, 968	9, 594, 774	118. 00
	NONREI MBURSABLE COST CENTERS				ما	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	0	0		190. 00 191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES		0		o o		191.00
	19300 NONPALD WORKERS			0	0		193. 00
200.00	Cross Foot Adjustments				٩		200. 00
201.00	Negative Cost Centers	n	n	1	n		201.00
202.00		1, 239, 025	70, 970	19, 667	59, 968		
1							•

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0191 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 10:48 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 1, 324, 886 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05100 RECOVERY ROOM 51.00 000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52 00 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 542, 126 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 Ω 05600 RADI 0I SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 06000 LABORATORY 60.00 1, 402, 632 60.00 06001 BLOOD LABORATORY 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0000000000000 62 00 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 57.022 07000 ELECTROENCEPHALOGRAPHY 70 00 C 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 257, 364 73.00 73.00 07400 RENAL DIALYSIS 74.00 C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISÍTION 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 09100 EMERGENCY 4, 010, 744 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 9, 594, 774 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 00000 191.00 191, 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 193. 00 19300 NONPALD WORKERS 0 193. 00 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers Ω 201.00 202.00 TOTAL (sum lines 118 through 201) 9, 594, 774 202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0191

				To	12/31/2023	Date/Time Pre 5/24/2024 10:	pared:
	Cost Center Description	Directly Assigned New	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	40 aiii
		Capi tal			DEPARTMENT		
		Related Costs 0	1. 00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	ZA	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	84, 349		0	,	5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	194, 066 31, 537		0	10, 893 385	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	7, 302		0	l e	9. 00
10.00	01000 DI ETARY	0	26, 501		0	l .	10.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	535, 870	535, 870	0	6, 674	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	0	O	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0		0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	Ō	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	375, 354		0	19, 453	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	)   0	0	0	0 1 0	56. 00 57. 00
58. 00	05800 MRI	0	Ö	Ö	0	ĺ	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	27, 256		0	12, 121	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	Ö	0	Ö	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	19, 640	0 19, 640	0	0 350	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 289		0	2, 152	73. 00
74. 00 75. 00	07400   RENAL DIALYSIS   07500   ASC (NON-DISTINCT PART)	0	0	0	0	0 0	74. 00 75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	Ö	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0		78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0		90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	397, 197	397, 197 0	0	31, 881	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>			72.00
102.00	10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS					r	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	1, 713, 361	1, 713, 361	0	84, 349	]118. 00 
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	•	192. 00
193. 00 200. 00	0 19300 NONPALD WORKERS Cross Foot Adjustments	0	0	0	0		193. 00 200. 00
200.00			n	0	0		200.00
202.00		0	1, 713, 361		0	l e	

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 Provider CCN: 15-0191

				Ic	12/31/2023	Date/lime Pre   5/24/2024 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Subtotal	TO alli
		PLANT	LINEN SERVICE				
		7.00	8. 00	9. 00	10.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	204, 959					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	4, 504	36, 426				8. 00
9.00	00900 HOUSEKEEPI NG	1, 043	0	8, 462			9. 00
10. 00	01000 DI ETARY	3, 785	0	161	30, 770		10. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	76, 542	18, 213	3, 248	30, 770	671, 317	30.00
	ANCILLARY SERVICE COST CENTERS	_	_		_1		
50.00	05000 OPERATING ROOM	0	0		0	0	
51. 00	05100 RECOVERY ROOM	0	0		0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	E2 412	0	0	0	0 450 405	
55. 00	05500 RADI OLOGY-THERAPEUTI C	53, 613		2, 275 0	0	450, 695 0	1
56. 00	05600 RADI OLOGI - ITIERAF LUTT C			0	0	0	56.00
57. 00	05700 CT SCAN	0		0	0	0	57. 00
58. 00	05800 MRI	0		0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		Ö	0	0	
60. 00	06000 LABORATORY	3, 893		165	0	43, 435	
60. 01	06001 BLOOD LABORATORY	0,070	0	0	0	0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				Ĭ.	ŭ	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	o	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 805	0	119	0	22, 914	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 041	0	87	0	18, 569	1
74. 00	07400 RENAL DI ALYSI S	0	0	0	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS				ام		00.00
90.00	09000 CLINIC	0			0	0	
91. 00	09100 EMERGENCY	56, 733	18, 213	2, 407	0	506, 431	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
100.00	OTHER REIMBURSABLE COST CENTERS		1 0		٥		100 00
102.00	10200   OPIOI	0	0	0	0	U	102. 00
118.00		204, 959	36, 426	8, 462	30, 770	1, 713, 361	110 00
110.00	NONREI MBURSABLE COST CENTERS	204, 737	30, 420	0, 402	30, 770	1, /13, 301	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH				0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	0	ol O		192. 00
	19300 NONPALD WORKERS	1 0		0	ol O		193. 00
200.00			I		J		200.00
201.00		0	1	n	ol		201. 00
202.00		204, 959	36, 426	8, 462	30, 770	1, 713, 361	
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Heal th Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0191 Period: Worksheet B

From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/24/2024 10:48 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 671, 317 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05100 RECOVERY ROOM 51.00 000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52 00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 450, 695 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 Ω 05600 RADI OI SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 Ω 06000 LABORATORY 60.00 43, 435 60.00 06001 BLOOD LABORATORY 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 00000000000000000 0 62 00 62 00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 22, 914 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 C 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 18, 569 73.00 07400 RENAL DIALYSIS 74.00 C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 506, 431 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 713, 361 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 00000 191.00 191, 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 193. 00 19300 NONPALD WORKERS 0 193.00 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers C 201.00 202.00 TOTAL (sum lines 118 through 201) 1, 713, 361 202.00

				Т	o 12/31/2023	Date/Time Pre 5/24/2024 10:	
		CAPI TAL				37 247 2024 10.	40 diii
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		
		(SQUARE FEET)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	
			(GROSS		(ACCOM. COST)	(SQUARE TELT)	
			SALARI ES)				
		1.00	4. 00	5A	5. 00	7. 00	
4 00	GENERAL SERVICE COST CENTERS	07.040					1 4 00
1. 00 4. 00	OO100   CAP REL COSTS-BLDG & FIXT   OO400   EMPLOYEE BENEFITS DEPARTMENT	27, 219	2 242 725	:			1. 00 4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 340	3, 242, 735 368, 675		7, 086, 051		5. 00
7. 00	00700 OPERATION OF PLANT	3, 083	000, 070			22, 796	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	501	0	0		1	8. 00
9.00	00900 HOUSEKEEPI NG	116	0	0			9. 00
10. 00	01000 DI ETARY	421	0	) 0	27, 113	421	10.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8, 513	617	'l 0	560, 679	8, 513	30.00
30.00	ANCILLARY SERVICE COST CENTERS	0, 515	017		300, 077	0, 313	30.00
50.00	05000 OPERATI NG ROOM	0	O	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	52. 00
53. 00 54. 00	05300  ANESTHESI OLOGY   05400  RADI OLOGY-DI AGNOSTI C	5, 963	1, 038, 366	0		0 5, 963	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 963	1,036,366			0, 903	55. 00
56. 00	05600 RADI OI SOTOPE		Ö	1 "	0	Ö	56. 00
57.00	05700 CT SCAN	o	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		0	59.00
60. 00 60. 01	06000  LABORATORY  06001  BLOOD   LABORATORY	433	0	0	1, 018, 224	433	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O	) 	0		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	0	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	0		0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	o o		Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	312	0	0	29, 384	312	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	227	1, 221	1	_	227	73. 00
74.00	07400 RENAL DIALYSIS	o	0	0		0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	_	0	75. 00
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0		0	77. 00 78. 00
76.00	OUTPATIENT SERVICE COST CENTERS	J U		<u>)</u>	0		76.00
90.00	09000 CLI NI C	0	C	0	0	0	90. 00
	09100 EMERGENCY	6, 310	1, 833, 856	0	2, 678, 434	6, 310	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS  10200 OPLOID TREATMENT PROGRAM	0	C	0	0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	l o		<u>)                                    </u>	0	0	102.00
118. 00		27, 219	3, 242, 735	-2, 508, 723	7, 086, 051	22, 796	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			l	190. 00
	19100  RESEARCH   19200  PHYSI CLANS'   PRI VATE   OFFI CES	0	0	0			191. 00 192. 00
	19300 NONPALD WORKERS		0		_	l	193. 00
200.00			Č	΄		Ĭ	200. 00
201.00							201. 00
202.00		1, 713, 361	613, 627	'	2, 508, 723	1, 239, 025	202. 00
203. 00	Part I)   Unit cost multiplier (Wkst. B, Part I)	62. 947243	0. 189231		0. 354037	54. 352737	202 00
203.00		02. 947243	0. 169231		84, 349	l	1
201.00	Part II)		Ö		01, 547	201,707	
205.00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 011904	8. 991007	205. 00
204 00	NAME adjustment amount to be allocated						206 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00							207. 00
	Parts III and IV)			1			

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0191 

				To		me Prepared: 24 10:48 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	37 247 202	10. 40 am
		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)		
		(GROSS CHAR GES)				
		8. 00	9. 00	10.00		
-	RAL SERVICE COST CENTERS	ı	1			
1	CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT					1.00
1	ADMINISTRATIVE & GENERAL					5. 00
	OPERATION OF PLANT					7. 00
	LAUNDRY & LINEN SERVICE	100	l .			8. 00
	HOUSEKEEPI NG   DI ETARY	0				9.00
	TIENT ROUTINE SERVICE COST CENTERS		421	100		10.00
	ADULTS & PEDIATRICS	50	8, 513	100		30.00
	LARY SERVICE COST CENTERS OPERATING ROOM	0		0		50.00
	RECOVERY ROOM					51.00
	DELIVERY ROOM & LABOR ROOM	0	O	l l		52. 00
	ANESTHESI OLOGY	0	0	0		53. 00
	D RADI OLOGY-DI AGNOSTI C D RADI OLOGY-THERAPEUTI C	0	5, 963			54. 00 55. 00
	RADI OLOGI - THERAFLOTT C					56.00
	CT SCAN	0	O	0		57. 00
58.00 05800	1	0	0			58.00
	CARDI AC CATHETERI ZATI ON LABORATORY	0	433			59. 00 60. 00
	BLOOD LABORATORY		433			60. 00
	PBP CLINICAL LAB SERVICES-PRGM ONLY					61. 00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62. 00
1	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0		0		64. 00 65. 00
	PHYSI CAL THERAPY	Ö	Ö	0		66. 00
	OCCUPATIONAL THERAPY	0	0			67. 00
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0 312	-1		68. 00 69. 00
	ELECTROCARDIOLOGY	0	312	1		70.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	1		71. 00
	IMPL. DEV. CHARGED TO PATIENTS	0	0	-1		72. 00
	DDRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	227	0		73. 00 74. 00
	ASC (NON-DISTINCT PART)					75. 00
	ALLOGENEIC HSCT ACQUISÍTION	0	O	0		77. 00
	CAR T-CELL IMMUNOTHERAPY	0	C	0		78. 00
	ATIENT SERVICE COST CENTERS   CLINIC	1 0		0		90.00
1	EMERGENCY	50				91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART		·			92. 00
	R REIMBURSABLE COST CENTERS OPIOID TREATMENT PROGRAM					102.00
	AL PURPOSE COST CENTERS	0	0	0		102. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100	22, 179	100		118. 00
	I MBURSABLE COST CENTERS		1			100.00
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0		190. 00 191. 00
	PHYSICIANS' PRIVATE OFFICES					192. 00
193.00 19300	NONPALD WORKERS	0	o	0		193. 00
200.00	Cross Foot Adjustments					200. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	70, 970	19, 667	59, 968		201. 00 202. 00
232.00	Part I)	70, 770	19,007	37, 700		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	709. 700000				203. 00
204.00	Cost to be allocated (per Wkst. B,	36, 426	8, 462	30, 770		204. 00
205. 00	Part II)   Unit cost multiplier (Wkst. B, Part	364. 260000	0. 381532	307. 700000		205. 00
233.00		304. 200000	0. 301332	337.700000		203.00
206. 00	NAHE adjustment amount to be allocated					206. 00
207 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					207.00
207. 00	Parts III and IV)					207. 00
ı	1	1	1	1		1

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/24/2024 10:	pared: 48 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 324, 886		1, 324, 88	6 0	1, 324, 886	30.00

					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						[
30. 00	03000 ADULTS & PEDI ATRI CS	1, 324, 886	)	1, 324, 886	0	1, 324, 886	30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	)	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	)	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	)	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	)	0	0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	2, 542, 126		2, 542, 126	0	2, 542, 126	54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	0	)	0	0	0	55. 00
56.00	05600  RADI 0I SOTOPE	0		0	0	0	56. 00
57.00	05700 CT SCAN	0		0	0	0	57. 00
58. 00	05800  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	1, 402, 632		1, 402, 632	0	1, 402, 632	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0	o	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	o	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	o	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	57, 022		57, 022	0	57, 022	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0.,522		0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	257, 364		257, 364	0	257, 364	
	07400 RENAL DI ALYSI S	0		0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
70.00	OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.00
90. 00	09000 CLINIC	0	)	0	0	0	90. 00
91. 00	09100 EMERGENCY	4, 010, 744	1	4, 010, 744		4, 010, 744	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	772, 850		772, 850		772, 850	
72.00	OTHER REIMBURSABLE COST CENTERS	772,000	1	772,000		772,000	72.00
102 00	10200 OPLOLD TREATMENT PROGRAM		)	n		n	102. 00
200.00		10, 367, 624		10, 367, 624	0		
201.00	,	772, 850		772, 850		772, 850	
202.00		9, 594, 774					
202.00	Total (See Histi detions)	1, 3,77, 114	ı	1,5,77,774	١	7, 374, 774	1202.00

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 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/24/2024 10:48 am
	T: 11 \0.00 1.1		DDC

					To 12/31/2023	Date/Time Pre 5/24/2024 10:	
		_	Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		•			
30.00	03000 ADULTS & PEDIATRICS	32, 240		32, 240			30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(	0.000000	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0	(	0.000000	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0. 000000	0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(	0. 000000	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	28, 352	16, 452, 231	16, 480, 583	0. 154250	0. 000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	0. 000000	0. 000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0	(	0. 000000	0. 000000	56. 00
57.00	05700 CT SCAN	0	0	(	0. 000000	0. 000000	57. 00
58.00	05800 MRI	0	0	(	0. 000000	0. 000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0. 000000	0. 000000	59. 00
60.00	06000 LABORATORY	43, 255	5, 722, 783	5, 766, 038	0. 243258	0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(	0. 000000	0. 000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	(	0. 000000	0. 000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(	0. 000000	0. 000000	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0. 000000	0. 000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(	0. 000000	0. 000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	(	0. 000000	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0. 000000	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(	0. 000000	0. 000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0. 000000	0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	33, 208	1, 979, 890	2, 013, 098	0. 028325	0. 000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0.000000	0. 000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0.000000	0. 000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0. 000000	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 507	1, 372, 609	1, 384, 116	0. 185941	0. 000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(	0.000000	0. 000000	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0. 000000	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0. 000000	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0.000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0			0. 000000	
91. 00	09100 EMERGENCY	18, 343	10, 557, 243			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 183	42, 561	54, 74	14. 117529	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS				1		
	10200 OPI OI D TREATMENT PROGRAM	0	0				102. 00
200.00	,	179, 088	36, 127, 317	36, 306, 40!			200. 00
201.00	1						201. 00
202.00	Total (see instructions)	179, 088	36, 127, 317	36, 306, 40			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	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/24/2024 10:48 am

			10 12/31/2023	5/24/2024 10: 48 am
		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. 154250			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   MRI	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00   06000   LABORATORY	0. 243258			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 CELL	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. 028325			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 185941			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 379246			91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	14. 117529			92. 00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPI OI D TREATMENT PROGRAM				102. 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	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/24/2024 10:	pared: 48 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 324, 886		1, 324, 88	6 0	1, 324, 886	30.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0			0	0	50. 00
E1 OO OE1OO DECOVEDY DOOM	1	1	I	0 0	^	

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 324, 886	)	1, 324, 886	0	1, 324, 886	30.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	C	)	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	C	)	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	)	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	C	)	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 542, 126		2, 542, 126	0	2, 542, 126	
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	)	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	C	)	0	0	0	56. 00
57. 00	05700 CT SCAN	C	)	0	0	0	57. 00
58. 00	05800  MRI	C	)	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	C	)	0	0	0	07.00
60. 00	06000 LABORATORY	1, 402, 632		1, 402, 632	0	1, 402, 632	60.00
60. 01	06001 BLOOD LABORATORY	C	)	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	C	)	0	0	0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	)	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		)	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY		]	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	C	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	C	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	57, 022		57, 022	0	57, 022	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	C	)	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	)	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		)	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	257, 364		257, 364	0	257, 364	73. 00
	07400 RENAL DIALYSIS		)	0	0	0	74.00
	07500 ASC (NON-DISTINCT PART)		)	0	0	0	
	07700 ALLOGENEIC HSCT ACQUISITION		)	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		)	0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00	09000 CLINIC	0 C	l .	4 010 744	0		, 0. 00
91.00	09100 EMERGENCY	4, 010, 744		4, 010, 744	0	1,0.0,7	
92. 00	09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	772, 850	1	772, 850		772, 850	92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	1 0	<u> </u>	1 0			102. 00
200.00	1	10, 367, 624		10, 367, 624	^	10, 367, 624	
200.00		772, 850	<b> </b>	772, 850	0	772, 850	
201.00	1 1	9, 594, 774			0	l	
202.00	Total (see Histiactions)	7, 374, 774	.1 0	7, 374, 774	U	7, 374, 774	1202.00

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 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/24/2024 10:48 am
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				-	To 12/31/2023	Date/Time Pre 5/24/2024 10:	
				e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		32, 240		32, 240			30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0			0. 000000	1
51. 00	05100 RECOVERY ROOM	0	0		0. 000000	0. 000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	1
53. 00	05300 ANESTHESI OLOGY	0	0	(		0. 000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C	28, 352	16, 452, 231			0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	0.00000	0.000000	
56. 00	05600 RADI OI SOTOPE	0	0	(		0.000000	
57. 00	05700 CT SCAN	0	0	9	0.00000	0.000000	
58. 00	05800 MRI	0	0	9		0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	40.055	U 5 700 700	5 7// 00/		0.000000	
60.00	06000 LABORATORY	43, 255	5, 722, 783			0.000000	
60. 01	06001 BLOOD LABORATORY	0	0			0.000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	1	0.000000	0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0.000000	0.000000	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0		0. 000000 0. 000000	0.000000	1
64. 00 65. 00			0			0.000000	
66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0		0. 000000 0. 000000	0. 000000 0. 000000	
67. 00	06700 OCCUPATIONAL THERAPY		0			0. 000000	1
68. 00	06800 SPEECH PATHOLOGY		0			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	33, 208	1, 979, 890	1		0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	33, 200	1, 7/7, 670	2,013,040		0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	1		0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 507	1, 372, 609			0. 000000	1
74. 00	07400 RENAL DIALYSIS	11,307	1, 372, 007	1, 304, 110		0.00000	1
75. 00	07500 ASC (NON-DISTINCT PART)		0		0.000000	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0		0.000000	0. 000000	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0.000000	0. 000000	1
70.00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	0.00000	0.00000	70.00
90. 00	09000 CLI NI C	0	0		0. 000000	0. 000000	90. 00
91. 00	09100 EMERGENCY	18, 343	10, 557, 243			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 183	42, 561			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	1=7.55	.=1 = 2 :				1
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(			102. 00
200.00		179, 088	36, 127, 317	36, 306, 40!	5		200. 00
201.00		1	. , ,				201. 00
202. 00		179, 088	36, 127, 317	36, 306, 40	5		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	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/24/2024 10:48 am

			10 12/31/2023	5/24/2024 10: 48 am
		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 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. 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 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 CELL	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 PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
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
OTHER REIMBURSABLE COST CENTERS				100.00
102.00 10200 OPI OI D TREATMENT PROGRAM				102.00
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	CON HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		nared.
				10 12/01/2020	5/24/2024 10:	48 am
		Titl∈	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	671, 317	ł .	671, 31			1
200.00 Total (lines 30 through 199)	671, 317		671, 31	7 36		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	/ 00	6)	1			
LNDATI ENT. DOUTLING OFFINIAGE COOK OFFITEDS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	10		1			30. 00
200.00 Total (lines 30 through 199)	10	186, 477	1			200. 00

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVIO	CE CAPITAL COSTS	Provider C	F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet D Part II Date/Time Pre 5/24/2024 10:4	
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II. col.	8)	2)			

					3/24/2024 10.	40 alli
		Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
· ·		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col .		column 4)	
	Part II, col.	8)	2)	g		
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		2.00	0.00		0.00	
50. 00 05000 OPERATI NG ROOM	0	0	0.000000	0	0	50.00
51. 00   05100   RECOVERY   ROOM		١	0. 000000		Ö	51.00
52. 00   05200   DELI VERY   ROOM & LABOR   ROOM			0. 000000		Ö	52. 00
53. 00   05300   ANESTHESI OLOGY			0. 000000		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	450, 695	14 400 503			554	54. 00
	450, 695	16, 480, 583		· ·	l	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0.000000		0	55.00
56. 00   05600   RADI OI SOTOPE	0	0	0.000000		0	56. 00
57. 00   05700   CT   SCAN	0	0	0. 000000		0	57. 00
58. 00   05800   MRI	0	0	0. 000000		0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	0. 000000		0	59. 00
60. 00   06000   LABORATORY	43, 435	5, 766, 038	0. 007533	3 29, 468	222	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 CELL	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	l o	0. 000000	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0. 000000		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 000000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	1	0. 000000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	22, 914	2, 013, 098			294	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	22, 711	2,010,070	0. 000000	· ·	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 000000		ĺ	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 000000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	18, 569	1, 384, 116			128	73.00
	10, 309	1, 304, 110			l .	74.00
	0	0	0.000000		0	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000		0	75. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 000000		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	T	T	1		Г	
90. 00 09000 CLI NI C	0	0				
91. 00   09100   EMERGENCY	506, 431					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	391, 602					
200.00   Total (lines 50 through 199)	1, 433, 646	36, 274, 165		113, 662	89, 130	200. 00

Health Financial Systems	FRANCISCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 200.00   Total (Lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 200.00   Total (lines 30 through 199)	0	0	1	6 6 0.00		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 0					30. 00 200. 00

Health Financial Systems	FRANCISCAN BEACON HOSPI	TAL In Li ε	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provi	der CCN: 15-0191 Period:	Worksheet D
THROUGH COSTS		From 01/01/2023	Part IV

				10 12/31/2023	Date/lime Pre 5/24/2024 10:	
		Title	XVIII	Hospi tal	PPS	40 diii
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
· ·	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0		0	0	50. 00
51.00   05100   RECOVERY ROOM	0	0		0	0	000
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		0	0	1
53. 00   05300   ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0		0	0	56. 00
57. 00  05700 CT SCAN	0	0		0	0	57. 00
58. 00   05800   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. 01   06001   BL00D   LABORATORY	0	0		0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64.00   06400   I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00   06500   RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90. 00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00   Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	FRANCISCAN BEAC	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN THROUGH COSTS	CILLARY SERVICE OTHER PASS	Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prep 5/24/2024 10:4	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description		Total Cost	Total		Ratio of Cost	
	Medical (	sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		` .	
		4)	1 0010 2 2	0)	71	

		Title	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	0	0	0	0.000000	50.00
51.00   05100   RECOVERY ROOM	0	0	0	0	0.000000	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0.000000	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	16, 480, 583	0.000000	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0.000000	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	0	0	0.000000	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0.000000	57. 00
58. 00   05800   MRI	0	0	0	0	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0. 000000	59. 00
60. 00 06000 LABORATORY	0	0	l o	5, 766, 038	0. 000000	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0	0	0. 000000	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0. 000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	2, 013, 098		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		1, 384, 116		
74. 00 07400 RENAL DIALYSIS	0	0		0	0. 000000	74. 00
75. 00   07500   ASC (NON-DISTINCT PART)	0	0	0	0	0. 000000	75. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0. 000000	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	1		0	0. 000000	
OUTPATIENT SERVICE COST CENTERS					0.00000	70.00
90. 00 09000 CLI NI C	0	0	0	0	0. 000000	90. 00
91. 00   09100   EMERGENCY	0			-		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			54, 744		
200.00 Total (lines 50 through 199)	0	0				200.00
200.00   Total (Titles 30 tillough 199)	1	ı	ı	30, 274, 103		<sub>1</sub> 200.00

Health Financial Systems	FRANCISCAN BEACON	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0191	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/24/2024 10:48 am

THROUGH COSTS				Γο 12/31/2023	Date/Time Prep 5/24/2024 10:4	
			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	T		ı .		_	
50. 00   05000   OPERATI NG ROOM	0. 000000	0	1	0	0	50.00
51. 00   05100   RECOVERY ROOM	0. 000000	0	(	0	0	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0	(	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	20, 261	(	4, 189, 908	1	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	0		0	0	56. 00
57. 00  05700   CT SCAN	0. 000000	0		0	0	57. 00
58. 00   05800   MRI	0. 000000	0		0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000	0	(	0	0	59. 00
60. 00  06000   LABORATORY	0. 000000	29, 468	(	447, 935	0	60.00
60. 01   06001   BL00D   LABORATORY	0. 000000	0	(	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	(	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	(	0	0	63. 00
64. 00   06400   I NTRAVENOUS THERAPY	0. 000000	0	(	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0	(	0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000	0	(	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	(	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	(	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	25, 829		887, 814	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	9, 577		361, 742	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
77.00 07700 ALLOĞENEIC HSCT ACQUISÍTION	0. 000000	0		0	ol	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	ol	78. 00
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLI NI C	0. 000000	0		0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	16, 344		1, 877, 255	o	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	12, 183		8, 600	o	92.00
200.00 Total (lines 50 through 199)	1	113, 662		7, 773, 254	0	200. 00
			•	•		•

From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 10:48 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52 00 Ω 52 00 0 0 05300 ANESTHESI OLOGY 0 53.00 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 154250 4, 189, 908 0 646, 293 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 55.00 C 0 0 05600 RADI OI SOTOPE 56.00 0.000000 C 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0 58.00 0.000000 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 0.000000 59 00 59 00 0 60.00 06000 LABORATORY 0. 243258 447, 935 108, 964 60.00 06001 BLOOD LABORATORY 0.000000 0 0 0 0 0 0 0 0 0 0 0 60.01 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62 00 0.000000 Ω 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 0 0 65.00 0 06600 PHYSI CAL THERAPY 0.000000 66.00 Ω 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 887, 814 69.00 0.028325 25, 147 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 185941 0 73.00 67, 263 73.00 361, 742 0 74.00 07400 RENAL DIALYSIS 0.000000 C Ω 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 0 78.00 Λ 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 0 0 09100 EMERGENCY 0 711, 941 91.00 0.379246 1,877,255 91.00

14. 117529

8, 600

7, 773, 254

7, 773, 254

121, 411

1, 681, 019 202. 00

1, 681, 019

0

0

0

0

0

92.00

200.00

201.00

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Subtotal (see instructions)

Only Charges

Health Financial Systems	FRANCISCAN BEACO	N HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, O	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0191	Peri od: From 01/01/2023	
				Date/Time Prepared:

				To 12/31/2023	Date/Time Pre 5/24/2024 10:	epared:
-		Title	e XVIII	Hospi tal	PPS	10 4111
	Cos			<u> </u>		
Cost Center Description	Cost	Cost				
, and the second	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	C	)			50. 00
51.00   05100   RECOVERY ROOM	0	C	1			51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	C	)			52. 00
53. 00   05300   ANESTHESI OLOGY	0	C	)			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C	)			54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	C	)			55. 00
56. 00   05600   RADI 0I SOTOPE	0	C	)			56. 00
57.00  05700   CT SCAN	0	C	)			57. 00
58. 00   05800   MRI	0	C	)			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	C	)			59. 00
60. 00   06000   LABORATORY	0	C	)			60.00
60. 01  06001 BL00D LABORATORY	0	C	)			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	)			63. 00
64.00   06400   I NTRAVENOUS THERAPY	0	C	)			64. 00
65. 00   06500   RESPI RATORY THERAPY	0	C	)			65. 00
66. 00   06600   PHYSI CAL THERAPY	0	C	)			66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	C	1			67. 00
68. 00   06800   SPEECH PATHOLOGY	0	C	)			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	C	)			69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	0	C	)			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	)			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C	1			73. 00
74. 00   07400   RENAL DI ALYSI S	0	C	1			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	1			75. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	C	1			77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	C	)			78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	C	1			90. 00
91. 00   09100   EMERGENCY	0	C	1			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	1			92. 00
200.00 Subtotal (see instructions)	0	C				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges		_				000 00
202.00   Net Charges (line 200 - line 201)	0	C	기			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 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/24/2024 10:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

-		Title XVIII	Hospi tal	5/24/2024 10: A	48 am_
	Cost Center Description	I tie will	1103pi tai	113	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		36	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			36	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		15	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period		04 6 11		
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
0.00	reporting period		1 -6 +1		0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	i days) arter beceiliber 3	i or the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	10	9. 00
10. 00	newborn days) (see instructions)	alv. (i nalveli na neivete e	aam daya)	0	10.00
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)	U <sub> </sub>	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		a maam daysa)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frictualing private	e room days)	U	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)	dir (excluding swing-bed	uays)	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	as through December 21 a	f the cost	0.00	17. 00
17.00	reporting period	es through becember 31 0	i the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	s through becomber 31 or	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		1, 324, 886	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 6	0	23. 00
23.00	x line 18)	of the cost reporting	g perrou (Trile o	·	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	R1 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perrou (rriie o	۱	20.00
26. 00	Total swing-bed cost (see instructions)	(1: 21 -: 1: 2/)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		1, 324, 886	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 =	lino 29)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 20)		0.00000	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	1, 324, 886	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			36, 802. 39	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	*		368, 024	
40.00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		368, 024	41. 00

COMPLIA	Financial Systems FATION OF INPATIENT OPERATING COST	FRANCISCAN BEAC	Provider C	°N· 15_∩101	Peri od:	u of Form CMS-: Worksheet D-1	
JOINIFU	ATTON OF INPATTENT OFENATING COST		Frovider C	SN. 13-0171	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 10:	pared:
		T		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	Thursday (1) I was well a	1.00	2. 00	3. 00	4. 00	5. 00	10.0
12.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	-e					42.00
13. 00		.3					43.00
14. 00	CORONARY CARE UNIT						44. 00
15. 00	BURN INTENSIVE CARE UNIT						45. 00
16.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
+7.00	Cost Center Description						47.00
	·					1. 00	
18.00	Program inpatient ancillary service cost (V			40		190, 998	
18. 01 19. 00	Program inpatient cellular therapy acquisit Total Program inpatient costs (sum of lines				column 1)	0 559, 022	
+ 7. 00	PASS THROUGH COST ADJUSTMENTS	3 41 till ough 40.01	/(see Thistruc	11 0113)		337, 022	47.00
50. 00	Pass through costs applicable to Program in	npatient routine s	ervices (from	Wkst. D, sur	m of Parts I and	186, 477	50.00
51. 00		npatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	89, 130	51.00
-2 00	and IV)	- 50 51)				275 (07	F2 0
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		ated non-phy	sician anestl	netist and	275, 607 283, 415	
00.00	medical education costs (line 49 minus line	9 1	atea, non pny	or er arr arres tr	ictist, and	200, 110	] 00.0
- 4	TARGET AMOUNT AND LIMIT COMPUTATION					=	
54. 00 55. 00	Program discharges Target amount per discharge					0	54.00
55. 01	Permanent adjustment amount per discharge						55. 0
55. 02	, ,					0. 00	55. 0
6. 00	Target amount (line 54 x sum of lines 55, 5			! F/!	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ating cost and tar	get amount (i	ine 56 minus	11 ne 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,		59.0
	updated and compounded by the market basket			0 .			
50. 00	Expected costs (lesser of line 53 ÷ line 54 market basket)	1, or line 55 from	prior year c	ost report, i	updated by the	0.00	60.0
51. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	esser of 50% of th	e amount by w	hich operatio	ng costs (line	0	61. 0
2 00	enter zero. (see instructions)					0	62. 00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
54. 00	Medicare swing-bed SNF inpatient routine co	osts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.0
55. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	osts after Decembe	r 31 of the c	ost reportin	period (See	0	65.0
	instructions) (title XVIII only)		. 0. 0. 1 0		g po ou (000		00.0
66. 00	Total Medicare swing-bed SNF inpatient rout	tine costs (line 6	4 plus line 6	5)(title XVI	I only); for	0	66. 0
57. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	f the cost re	eporting period	0	67.0
58. 00	(line 12 x line 19)	· ·				0	
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient						69. 0
	PART III - SKILLED NURSING FACILITY, OTHER						]
70.00	Skilled nursing facility/other nursing faci				)		70.00
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ne /u ÷ line	۷)			71.0
73. 00	Medically necessary private room cost appli		(line 14 x li	ne 35)			73. 0
74. 00	Total Program general inpatient routine ser	,	,				74. 0
75. 00	Capital-related cost allocated to inpatient 26, line 45)	t routine service	costs (from W	orksheet B, I	Part II, column		75. 0
76. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 0
77. 00	Program capital -related costs (line 9 x lir	ne 76)					77. 0
	Inpatient routine service cost (line 74 mir		ovi dom :	6)			78. 0
79. 00 30. 00				*	nus line 79)		79. 0 80. 0
31. 00	Inpatient routine service costs for com	•	or rimitation	(1110 70 1111	11110 77)		81. 0
32. 00	Inpatient routine service cost limitation (	(line 9 x line 81)					82. 0
33.00	Reasonable inpatient routine service costs	•	)				83.0
34. 00 35. 00	Program inpatient ancillary services (see i Utilization review - physician compensation		s)				84. 0 85. 0
	Total Program inpatient operating costs (su						86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PA						07.
37. 00	Total observation bed days (see instruction					21	
38. 00	Adjusted general inpatient routine cost per	diem (line 27 ·	line 2)			36, 802. 39	

Health Financial Systems	FRANCI SCAN BEA	CON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2023	Worksheet D-1	
				To 12/31/2023		
		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	671, 317	1, 324, 886	0. 50669	8 772, 850	391, 602	90.00
91.00 Nursing Program cost	0	1, 324, 886	0.00000	0 772, 850	0	91.00
92.00 Allied health cost	0	1, 324, 886	0.00000	0 772, 850	0	92.00
93.00 All other Medical Education	0	1, 324, 886	0. 00000	0 772, 850	0	93.00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0191	Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/24/2024 10:	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

DITECT ALL PRODUCE COMPONENTS  1.00    Popular I. ALL PRODUCE COMPONENTS   1.00   Inpatient days (Including private room days and swing-bed days, excluding nestorm)   36   1.00   Inpatient days (Including private room days, excluding sain pa-bed and nesborn days)   36   2.00   Inpatient days (Including private room days, excluding sain pa-bed and nesborn days)   36   2.00   And the room days (excluding sain pa-bed and observation bed days)   1.7 you have only private room days.   36   2.00   And the room days (excluding sain pa-bed and observation bed days)   36   30   30   30   30   30   30   30			Title XIX	Hospi tal	5/24/2024 10: Cost	48 am_
Impatient days (Including private room days and sering-bed days, excluding seaborn)   1.00		Cost Center Description	THE XIX	nospi tai		
IMPARTERN TANS		DADT I ALL DDOVIDED COMPONENTS			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)   36   1.00						-
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SNF type inpattent days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  7.00 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  7.00 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  8.00 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (in pattern to the pattern days).  9.00 Total input ent days including private room days applicable to the Program (excluding swing-bed and nexborn days) (see instructions).  10.00 Swing-bed SNF type inpattent days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (in its XVIII only (including private room days) after through December 31 of the cost reporting period (in its XVIII only (including private room days) after through December 31 of the cost reporting period (in its XVIII only (including private room days) after through December 31 of the cost reporting period (in its XVIII only (including private room days) after through December 31 of the cost reporting period (in its XVIII only (including private room days) after through December 31 of the cost reporting period (in its XVIII only (including private room days) after December 31 of the cost reporting period (in its XVIII only (including private room days) after December 31 of the cost reporting period (in its XVIII only (including private room days) after December 31 of the cost reporting period (in its XVIII only (including private room days) after December 31 of the						
do not complete this line.  4. 05 Semi-private room days (excluding soling-bed and observation bed days)  1. 10 Total sail ng-bed SNF type inpatient days (including private room days) after December 31 of the cost  7. 00 Total sail ng-bed SNF type inpatient days (including private room days) after December 31 of the cost  7. 00 Total sain g-bed SNF type inpatient days (including private room days) after December 31 of the cost  7. 00 Total sain g-bed SNF type inpatient days (including private room days) after December 31 of the cost  7. 00 Total sain g-bed SNF type inpatient days (including private room days) after December 31 of the cost  7. 00 Total sain g-bed SNF type inpatient days (including private room days) after December 31 of the cost  7. 00 Total sain g-bed SNF type inpatient days (including private room days) after December 31 of the cost  8. 00 SNing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and needs on days) (see instructions)  8. 00 SNing-bed SNF type inpatient days applicable to title XNIII only (including private room days) after  10. 00 Sing-bed SNF type inpatient days applicable to title XNIII only (including private room days) after  11. 00 Sing-bed SNF type inpatient days applicable to title XNIII only (including private room days) after  12. 00 Sing-bed SNF type inpatient days applicable to title XNIII only (including private room days) after  13. 00 SNING-bed NF type inpatient days applicable to title XNIII only (including private room days)  14. 00 SNING-bed NF type inpatient days applicable to title XNIII only (including private room days)  15. 00 SNING-bed NF type inpatient days applicable to title XNIII only (including private room days)  16. 00 SNING-bed NF type inpatient days applicable to title XNIII only (including private room days)  17. 00 SNING-bed NF type inpatient days applicable to title XNIII only (including private room days)  18. 00 SNING-bed NF type inpatient days applicable to services through December 31 of the cost  18. 00 SNING-bed N						
Seel - private room days (excluding swing-bed and observation bed days)   1	3.00		(S). If you have only pr	ivate room days,	) 	3.00
reporting period (1f cal endar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (1f cal endar year, enter 0 on this line)  8. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (1f cal endar year, enter 0 on this line)  9. 00 Iotal inpatient days including private room days after December 31 of the cost reporting period (1f cal endar) year, enter 0 on this line)  10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11. 00 Swing-bed SNF type inpatient days applicable to titles XV or XIX only (including private room days)  12. 00 Swing-bed NF type inpatient days applicable to titles XV or XIX only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to titles XV or XIX only (including private room days)  14. 00 Nedically necessary private room days applicable to titles XV or XIX only (including private room days)  15. 00 Iotal nursery days (title V or XIX only)  16. 00 Neuropean SV (title V or XIX only)  17. 00 Neuropean SV (title V or XIX only)  18. 00 Neuropean SV (title V or XIX only)  18. 00 Neuropean SV (title V or XIX only)  19. 00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  18. 00 Neuropean SV (title V or XIX only)  19. 00 Neuropean SV (title V or XIX only)  19. 00 Neuropean SV (title V or XIX only)  19. 00 Neuropean SV (title V or XIX only)  19. 00 Neuropean SV (title V or XIX only)  19. 00	4.00		ed days)		15	4.00
Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost or reporting period (if cf cal endar year, enter 0 on this line)	5.00		om days) through Decembe	r 31 of the cost	0	5. 00
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Total swing-bed NF type inpatient days (including private room days) arter December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   1	7.00		n days) through December	31 of the cost	0	7. 00
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21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average per diem private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Private room cost differential (line 3 x line 35)  36.00 Private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  36.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Medically necessary private room cost applicable to the Program (line 14	20. 00		after December 31 of t	he cost	0.00	20. 00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average per diem private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  37.00 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 1, 324, 886)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21. 00	' " "	5)		1. 324. 886	21. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 35)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  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)  36,802 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00  0 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Swing-bed cost applicable to SNF type services through December		ing period (line		22. 00
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 1,324,886  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.00000  32.00 Average private room per diem charge (line 29 + line 3) 0.00  33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00  35.00 Average per diem private room charge differential (line 34 x line 31) 0.00  36.00 Private room cost differential adjustment (line 3 x line 35) 0.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886) 0.00  38.00 Alyerage per diem private room cost diefferential (line 3 x line 31) 0.00  39.00 Private room cost diefferential adjustment (line 3 x line 35) 0.00  Average per diem private room cost diefferential (line 3 x line 35) 0.00  39.00 Program general inpatient routine service cost per diem (see instructions) 36.802.39  30.00 Alyerage general inpatient routine service cost per diem (see instructions) 36.802.39  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00	22 00	· · · · · · · · · · · · · · · · · · ·	21 of the cost reporting	a ported (Line 6		22 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		of the cost reporting	g perrou (Trile o	ا	25.00
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 FRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 30 + line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886) 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 (line 9 x line 38) 36. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	24. 00		31 of the cost reporti	ng period (line	0	24. 00
x line 20)  26. 00  Total swing-bed cost (see instructions)  27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  31. 00  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00  Average per diem private room charge differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Drivate room cost differential adjustment (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  Average linpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 26. 00  26. 00  27. 00  28. 00  28. 00  29. 0	25 00	· · · · · · · · · · · · · · · · · · ·	31 of the cost reporting	period (line 8	0	25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 ± line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  Private room cost differential dijustment (line 3 x line 35)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)		x line 20)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 1	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  Private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31. 00  32. 00  Average private room per diem charge (line 29 ÷ line 3)  32. 00  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34. 00  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  Adjusted general inpatient routine service cost per diem (see instructions)  36. 800  Adjusted general inpatient routine service cost per diem (see instructions)  36. 802. 39  Program general inpatient routine service cost (line 9 x line 38)  36. 802. 39  40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  28. 00  29. 00  20. 00  30. 00		, ,	(line 21 minus line 24)		-	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  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) 36,802 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 30.00 0 0 0 0.00 30.00 0 0.00 30.00 0 0.00 31.00 0 0.00 32.00 0 0 0.00 32.00 0 0 0.00 32.00 0 0 0.00 32.00 0 0 0.00 32.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00		Title 21 IIITius Title 20)		1, 324, 660	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  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) 36,802 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			d and observation bed ch	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 324, 886)  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)  36,802.39  37.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 0.00 32.00  0.00 32.00  0.00 32.00  0.00 33.00  0.00 33.00  0.00 33.00  0.00 33.00  0.00 33.00  0.00 34.00  36.00  37.00 General inpatient routine service cost and private room cost differential (line 1, 324, 886)  37.00 37.00  38.00 Average per diem private room cost differential (line 1, 324, 886)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost applicable to the Program (line 14 x line 35)  0.00 34.00					-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  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) 36,802 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 34.00 0.00 34.00 0.00 34.00 0.00 34.00 0.00 34.00 0.00 35.00 0.00 36.00 0.00		, , , , , , , , , , , , , , , , , , , ,	- line 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  36,802.39  37.00 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			11116 20)			1
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  34.00 34.00 35.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.0		, , , , , , , , , , , , , , , , , , , ,				1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  36.00 37.00  37.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  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	35.00				0. 00 <sup>1</sup>	35. 00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  36,802.39 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	36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  36,802.39  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 di	fferential (line	1, 324, 886	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36,802.39  38.00  36,802.39  36,802  39.00  40.00						1
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) 36,802 39.00 40.00			ISTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00				36, 802. 39	38. 00
		, , ,	•		36, 802	
41.00   lotal Program general inpatient routine service cost (line 39 + line 40)   36,802   41.00		, , , , , , , , , , , , , , , , , , , ,				
	41.00	Tiotal Program general inpatient routine service cost (line 39	+ IINE 4U)	l	36, 802	41.00

	Financial Systems	FRANCISCAN BEA				u of Form CMS-	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/24/2024 10:	pared:
	Cost Center Description	Total Inpatient Cost	Total	e XIX Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	T	1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	·s					42. 00
43. 00	INTENSIVE CARE UNIT	.5					43. 00
44.00	CORONARY CARE UNIT						44. 00
45.00							45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	T=					1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Verogram inpatient cellular therapy acquisition)			III lino 10	column 1)	2, 458	48. 00 48. 01
	Total Program inpatient costs (sum of lines				, corumin r)	39, 260	49. 00
	PASS THROUGH COST ADJUSTMENTS		, (				
50.00	Pass through costs applicable to Program in	npatient routine	services (from	n Wkst. D, su	m of Parts I and	0	50.00
51. 00		nnatient ancillar	v services (fr	com Wkst D	sum of Parts II	0	51.00
31.00	and IV)	ipatrent anerrai	y services (ii	oli wkst. b,	sum of farts fr		31.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line		lated, non-phy	sician anest	hetist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	5 52)					1
54.00						-	54.00
55. 00	Target amount per discharge						55.00
55. 01 55. 02	, ,	ruse only)					55. 01 55. 02
56. 00						0.00	1
57.00	Difference between adjusted inpatient opera	ating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	or line EE from	the cost rone	erting ported	anding 1004	0	58. 00 59. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket		i the cost repo	orting period	ending 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54		m prior year o	cost report,	updated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	esser of 50% of t	he amount by w	which operati	ng costs (line	0	61. 00
	enter zero. (see instructions)	,,	3	•	•		
62. 00 63. 00		mant (saa instru	ictions)				62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ymerit (see riistro	icti ons)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine co	osts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00
65 OO	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	osts after Decemb	or 21 of the c	cost roportin	a pariod (Saa	_	65. 00
03.00	instructions) (title XVIII only)	osts arter becenic	iei 31 di the c	ost reporting	g perrou (see		05.00
66.00	Total Medicare swing-bed SNF inpatient rout	tine costs (line	64 plus line 6	5)(title XVI	<pre>II only); for</pre>	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	of the cost r	enorting period	n	67. 00
07.00	(line 12 x line 19)	ne costs timougi	December of c	THE COST I	opor tring period	Ü	07.00
68. 00		ne costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	t routine costs (	line 67 + line	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY	, AND ICF/IID	ONLY			1
70.00	Skilled nursing facility/other nursing faci	,		•	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ine 70 ÷ iine	2)			71.00
73. 00	Medically necessary private room cost appli	,	(line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine ser	•					74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	t routine service	costs (from V	Vorksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ I	ine 2)					76.00
77.00	Program capital-related costs (line 9 x line)	,					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 mir Aggregate charges to beneficiaries for exce	,	rovi den record	ls)			78. 00 79. 00
80.00	Total Program routine service costs for cor				nus line 79)		80.00
81.00	Inpatient routine service cost per diem lir	ni tati on			•		81.00
82.00	1 '	•	•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	13)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ins)				85.00
86. 00	3 1 3 1		rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PARTOTAL observation bed days (see instruction					21	87. 00
88. 00	Adjusted general inpatient routine cost per		line 2)			36, 802. 39	
00.00	Observation bed cost (line 87 x line 88) (s					772, 850	1

Health Financial Systems	FRANCI SCAN BEA	CON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023		
		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	671, 317	1, 324, 886	0. 50669	8 772, 850	391, 602	90.00
91.00 Nursing Program cost	0	1, 324, 886	0.00000	772, 850	0	91.00
92.00 Allied health cost	0	1, 324, 886	0.00000	772, 850	0	92.00
93.00 All other Medical Education	0	1, 324, 886	0.00000	772, 850	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0191	In Lie	Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 10:	
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	04.050		4
00 03000 ADULTS & PEDI ATRI CS			24, 058		30
ANCILLARY SERVICE COST CENTERS		0.0000	00 0		٦.
00   05000   0PERATING ROOM 00   05100   RECOVERY ROOM		0.0000		0 0	
00   05200   DELIVERY ROOM & LABOR ROOM		0.0000		0	
00   05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY		0.0000		0	
00   05400   RADI OLOGY		0. 0000		3, 125	
00   05500 RADI OLOGY-THERAPEUTI C		0. 1542		3, 123	
00   05600   RADI 0I SOTOPE		0.0000		0	
00   05700   CT   SCAN		0.0000		0	
00   05800   MRI		0.0000		Ö	
00 05900 CARDI AC CATHETERI ZATI ON		0.0000		Ö	
00 06000 LABORATORY		0. 2432		7, 168	
01 06001 BLOOD LABORATORY		0.0000		0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		Ō	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
00 06400 I NTRAVENOUS THERAPY		0.0000	00 0	0	64
00 06500 RESPI RATORY THERAPY		0.0000	00 0	0	65
00 06600 PHYSI CAL THERAPY		0.0000	00 0	0	66
00 06700 OCCUPATI ONAL THERAPY		0.0000	00 0	0	67
00 06800 SPEECH PATHOLOGY		0.0000	00 0	0	68
00 06900 ELECTROCARDI OLOGY		0. 0283	25 25, 829	732	69
00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000		0	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1859			
00 07400 RENAL DI ALYSI S		0.0000		0	
00   07500   ASC (NON-DISTINCT PART)		0.0000		0	
00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000		0	
00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78
OUTPATIENT SERVICE COST CENTERS  00 09000 CLINIC		0.0000	00 0	0	90
		0.0000		_	
00   09100   EMERGENCY 00   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART		0. 3792 14. 1175		6, 198 171, 994	
00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 00 Total (sum of lines 50 through 94 and 96 through 98)		14. 11/5.	113, 662	171, 994	
.00 Less PBP Clinic Laboratory Services-Program only charges	(line 41)		113, 662	190, 998	201
2.00 Net charges (line 200 minus line 201)	(IIIIG OI)		113, 662	ı	201

Health Financial Systems FRANCISCAN BEAC		ON 15 0101		u of Form CMS-1	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2023	Worksheet D-3	5
			To 12/31/2023	Date/Time Pre 5/24/2024 10:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	2, 729		30.00
ANCI LLARY SERVI CE COST CENTERS		1	2, 121		30.00
50. 00   05000   OPERATI NG ROOM		0.00000	00	0	50.00
51. 00   05100   RECOVERY   ROOM		0.00000		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
53. 00   05300   ANESTHESI OLOGY		0.00000	00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15425	2, 707	418	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C		0.00000	00	0	55.00
56. 00   05600   RADI OI SOTOPE		0.00000	00	0	56. 00
57. 00   05700   CT   SCAN		0.00000		0	
58. 00   05800   MRI		0.00000		0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0.00000		0	
60. 00   06000   LABORATORY		0. 24325		1, 073	
60. 01   06001   BLOOD LABORATORY 61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000 0. 00000		0	1
63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.		0.00000		0	
64. 00   06400   NTRAVENOUS THERAPY		0.00000		0	
65. 00   06500   RESPI RATORY   THERAPY		0.00000		0	
66. 00   06600   PHYSI CAL THERAPY		0. 00000		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 02832	7, 379	209	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000	00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 18594		184	
74. 00   07400   RENAL DI ALYSI S		0.00000		0	1
75. 00   07500   ASC (NON-DISTINCT PART)		0.00000		0	
77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON		0.00000		0	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0	0	78. 00
90. 00 O9000 CLINIC		0.0000	0	0	90.00
91. 00   09100   EMERGENCY		0. 00000 0. 37924		574	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		14. 11752		0	
200 00 Total (sum of lines 50 through 94 and 96 through 98)		11.11732	17 001		200.00

201. 00 202. 00

574 91. 00 0 92. 00 2, 458 200. 00

17, 001

17, 001

200.00

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

	Title XVIII Hospital	PPS	10 4111
		1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments	0 28, 465	1. 00 1. 01
	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9, 488	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2. 03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instructions) Managed Care Simulated Payments	0	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	7. 94	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	0.00	5. 00
5. 01	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0. 00	6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0. 00	6. 26
7. 00 7. 01	MMMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 00 0. 00	7. 00 7. 01
	cost report straddles July 1, 2011 then see instructions.		
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0. 00	7. 02
8. 00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0. 00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	
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 14. 00	Total allowable FTE count for the prior year.  Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0.00	13. 00 14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00
16. 00			16. 00
17. 00	Adjustment for residents displaced by program or hospital closure		17. 00
18. 00	Adjusted rolling average FTE count	0.00	
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19. 00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)	0. 000000 0. 000000	20. 00 21. 00
22. 00	IME payment adjustment (see instructions)	0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$ .	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 lower of line 23 or line 24 (see instructions)	0. 00	
26. 00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions)	0. 000000 0	27. 00 28. 00
28. 00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)	0	28. 00
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	0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	0. 00	
32.00	Sum of lines 30 and 31	0.00	
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)		33. 00 34. 00
	12. 25. 25. 1. 2. data distance dell'accomment (200 militari dell'ono)	0	3 1. 00

	Financial Systems FRANCISCAN E ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0191	Peri od:	u of Form CMS-2 Worksheet E	2002-10
			From 01/01/2023 To 12/31/2023	Part A Date/Time Pre 5/24/2024 10:	pared: 48 am
		Title XVIII	Hospi tal	PPS	10 diii
			Prior to 10/1		
	Uncompensated Care Payment Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		0	0	35. 00
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	Hospital UCP, including supplemental UCP (see instruction	· ·	0	0	35. 02
35. 03	Pro rata share of the hospital UCP, including supplementa		0	0	35. 03
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiar		(db. 46)		36.00
40. 00	Total Medicare discharges (see instructions)	y di seriai ges (1111es 40 tili oc	0		40. 00
41.00	Total ESRD Medicare discharges (see instructions)		0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges (see inst		0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not o	qualify for adjustment)	0.00		42. 00 43. 00
44. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0. 000000		44.00
00	days)	aca syo a.v.aca sy .	0.00000		
45. 00	Average weekly cost for dialysis treatments (see instruct	,	0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line (15 times line 44 times line 45 times lin	ne 41.01)	0		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MI	OH small rural hospitals	37, 953 0		47. 00 48. 00
10. 00	only. (see instructions)	on, smarr rarar nospi tars			10.00
49. 00	Total payment for inpatient operating costs (see instructions)	tions)		1. 00 37, 953	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt.	,	)	2, 793	
51.00	Exception payment for inpatient program capital (Wkst. L,			0	51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4	4, line 49 see instructions).		0	
53. 00 54. 00	Nursing and Allied Health Managed Care payment			0	53. 00 54. 00
54. 00	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Ii	ne 69)		0	55. 00
55. 01	Cellular therapy acquisition cost (see instructions)			0	55. 01
56.00	Cost of physicians' services in a teaching hospital (see	•	hh	0	56.00
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Ancillary service other pass through costs from Wkst. D,		through 35).	0	57. 00 58. 00
59. 00	Total (sum of amounts on lines 49 through 58)	11. 11, 661. 11 11116 266)		40, 746	1
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 m	minus line 60)		40, 746	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			9, 556 0	
64. 00	Allowable bad debts (see instructions)			7, 708	1
65.00	Adjusted reimbursable bad debts (see instructions)			5, 010	
66. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	66. 00
67.00	1	for applicable to MS DDCs (	soo instructions)	36, 200 0	1
69. 00	Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and			0	
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	70). (. 0. 00 000	.5)	0	1
70. 50	Rural Community Hospital Demonstration Project (§410A Der		instructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instruction			0	1
70. 87 70. 88	Demonstration payment adjustment amount before sequestrations SCH or MDH volume decrease adjustment (contractor use only			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see	•		U	70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instruction			0	
70. 91	HSP bonus payment HRR adjustment amount (see instructions	s)		0	
70. 92				0	70. 92
70. 93	HVBP payment adjustment amount (see instructions)			0	1
70 Q/	HRR adjustment amount (see instructions)				

Heal th	Financial Systems	FRANCISCAN BEACON	I HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der Co	CN: 15-0191	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/24/2024 10:	
			Title	XVIII	Hospi tal	PPS	
				FFY	(уууу)	Amount	
					0	1. 00	
70. 96	Low volume adjustment for federal fiscal y the corresponding federal year for the per		n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal y the corresponding federal year for the per				0	0	70. 97
70. 98	Low Volume Payment-3				0	0	70. 98
70. 99	HAC adjustment amount (see instructions)					0	70. 99
71.00	Amount due provider (line 67 minus lines 6	58 plus/minus lines 6	59 & 70)			36, 200	71. 00
71. 01	Sequestration adjustment (see instructions	s)				724	71. 01
71. 02	Demonstration payment adjustment amount af	fter sequestration				0	71. 02
71 02	Cognection adjustment DADIM need through	who.		I	i		71 02

71.03 | Sequestration adjustment-PARHM pass-throughs

71. 02 71. 03

	71. 03	Sequestration adjustment-PARHM pass-throughs		20 545	71. 03
		Interim payments		30, 505	1
	72. 01	Interim payments-PARHM		0	72. 01
		Tentative settlement (for contractor use only)		U	73. 00
	73. 01	Tentative settlement-PARHM (for contractor use only)		4 011	
	74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		4, 911	74. 00
	74. 01	Balance due provider/program-PARHM (see instructions)			74. 01
	75.00	Protested amounts (nonallowable cost report items) in accordance with		234, 266	75. 00
		CMS Pub. 15-2, chapter 1, §115.2			
		TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
	90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. 00
		plus 2.04 (see instructions)			
	91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0	
	92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0	
	93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	
	94. 00	The rate used to calculate the time value of money (see instructions)		0.00	
	95.00	Time value of money for operating expenses (see instructions)		0	
	96. 00	Time value of money for capital related expenses (see instructions)		0	96. 00
			Prior to 10/1		
			1. 00	2. 00	
		HSP Bonus Payment Amount	1		
	100.00	HSP bonus amount (see instructions)	0	0	100. 00
		HVBP Adjustment for HSP Bonus Payment			
		HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)				0	102. 00
		HRR Adjustment for HSP Bonus Payment			
		HRR adjustment factor (see instructions)	0.0000	0. 0000	1
	104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	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.			
	004 00	Cost Reimbursement			004 00
		Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
		Medicare discharges (see instructions)			202. 00
	203.00	Case-mix adjustment factor (see instructions)			203. 00
		Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)	5-year demonst	ration	
		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
		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			
		Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
		Low-volume adjustment (see instructions)			213. 00
	210 00	Not Modicare Dart A LDDS adjustment (difference between DDS and cost reimbursement)			
	218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
	218.00	(line 212 minus line 213) (see instructions)			218.00

Health Financial Systems	FRANCISCAN BEACON HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0191	Peri od: Worksheet E From 01/01/2023 Part B To 12/31/2023 Date/Ti me Prepared: 5/24/2024 10:48 am

Note 1		Title XVIII Hospital	PPS	<del>10 alli</del>
Note			1.00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
0.00   Comparison   0.00   0	1.00		0	1.00
0.01   Continuer payment (see instructions)				
0.000   0.00				
Earther The hospit plat specific payment to cost ratio (see instructions)				
2.00   Same of Fines 3 . 4, and 4.01, divided by line 6   0.00   7.00		1		
Transit foral corridor payment (see instructions)	6.00			
Ancil Tlary service other pass through costs including REH direct graduate medical education costs from Nature 10, 13, 1 in 200   0.00				
West				
10.00   Grgan acquist items   0   10.00   11.00   11.00   10.00   15.00   15.00   15.00   11.00   11.00   15	9.00			9.00
COMPUTATION for LESSER OF COST OR CHARGES   Reasonable charges	10.00		0	10.00
Reasonable charges	11. 00		0	11. 00
12.00				-
13.00   Organ acquist ion charges (From West, D-4, Pt. III. cel. 4, line 69)	12 00		0	12 00
14.00				
15.00   Aggregate amount actually collected from patients   1able for payment for services on a charge basis   0   15.00	14.00	Total reasonable charges (sum of lines 12 and 13)	0	14. 00
16.00   Amounts that would have been real ized from patients liable for payment for services on a chargebasis   0   16.00   Nature payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00   0.000000   17.00   18.00   19	45.00			45.00
had such payment been made in accordance with 42 CFR \$413.13(e)*		, 00 0		
17.00	10.00			10.00
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   20. 00	17. 00		0. 000000	17. 00
instructions				
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0.20.00	19. 00		0	19. 00
instructions	20. 00		0	20.00
22.00   Interns and residents (see instructions)   0.22.00   0.23.00   0.24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   1, 122, 518   24.00   0.25.00				
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0   22.00				
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1	_	
COMPUTATION OF RELIMBURSEMENT SETTLEMENT				
26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   242, 180   26.00   27.00   28.00   2	21.00		17 1227 010	2 00
27.00   Subtotal   [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   28.00				
Instructions				
28.00   Direct graduate medical education payments (From Wkst. E-4, line 50)   28.00   28.50   28.50   28.50   28.50   28.50   28.50   28.50   28.50   28.50   28.50   28.50   28.50   28.50   29.00   28.50   28.50   29.00   28.50   29.00   28.50   29.00   28.50   29.00   28.50   29.00   28.50   29.00   28.50   29.00   28.50   29.00   28.50   29.00   28.50   29.00	27.00		880, 338	27.00
29.00   ESRD direct medical education costs (From Wkst. E-4, line 36)   29.00   30.0	28. 00		0	28. 00
30. 00   Subtotal (sum of lines 27, 28, 28. 50 and 29)   880, 338   30. 00   9   Primary payer payments   503   31. 00   32. 00   Subtotal (line 30 minus line 31)   879, 835   32. 00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   879, 835   32. 00   Composite rate ESRD (from West. 1-5, line 11)   0   33. 00   33. 00   All lowable bad debts (see instructions)   20, 165   34. 00   33. 00   All lowable bad debts (see instructions)   13, 107   35. 00   37. 00   All lowable bad debts for dual eligible beneficiaries (see instructions)   13, 907   36. 00   38. 00   MSP-LCC reconciliation amount from PS&R   992, 942   37. 00   39. 00	28. 50	REH facility payment amount (see instructions)		28. 50
31.00   Primary payer payments   So3   31.00   Subtotal (line 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   Some state   SSRD (From Wkst.   -5, line 11)   O   33.00   O   O   O   O   O   O   O   O   O				
32.00   Subtorial (line 30 minus line 31)   879,835   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   20,165   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   13, 107   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   13, 107   36.00   37.00   Subtorial (see instructions)   892,942   37.00   Subtorial (see instructions)   892,942   37.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   97.50				1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   20,165   34.00   34.00   Adjusted reimbursable bad debts (see instructions)   13, 107   35.00   Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions)   13, 107   36.00   37.00   Subtotal (see instructions)   892, 942   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCT reconciliation amount from PS&R   0   39.00   07   07   07   07   07   07   07				
34. 00   All lowable bad debts (see instructions)   20,165   34, 00   30.				
35.00   Adjusted reimbursable bad debts (see instructions)   13, 107   35.00   30.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   13, 907   36.00   38.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   39				1
36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)       13,907 36.00         37. 00 Subtotal (see instructions)       892,942 37.00         38. 00 MSP-LCC reconciliation amount from PS&R       0 38.00         39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 39.50         39. 50 Pioneer ACO demonstration payment adjustment (see instructions)       39.50         39. 75 N95 respirator payment adjustment amount (see instructions)       0 39.75         39. 97 Demonstration payment adjustment amount before sequestration       0 39.75         39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)       0 39.99         40. 00 Subtotal (see instructions)       892,942 40.00         40. 01 Sequestration adjustment (see instructions)       892,942 40.00         40. 02 Demonstration payment adjustment amount after sequestration       17,859 40.01         40. 02 Demonstration payment adjustment amount after sequestration       40.02         40. 02 Demonstration adjustment dispersable to adjust ment amount after sequestration       40.02         41. 00 Interim payments       862,374 41.00         41. 01 Interim payments-PARHM       42.00         42. 01 Tentative settlement (for contractors use only)       42.01         43. 00 Balance due provider/program-PARHM (see instructions)       43.01         44. 00 Protested amounts (non				
37.00   Subtotal (see instructions)   892,942   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   39.50   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   39.		, , , , , , , , , , , , , , , , , , ,		
38. 00       MSP-LCC reconciliation amount from PS&R       0       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       39. 50         39. 75       N95 respirator payment adjustment amount (see instructions)       0       39. 75         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 97         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 01       Sequestration adjustment (see instructions)       80. 9. 99         40. 02       Sequestration adjustment (see instructions)       87. 94       40. 00         40. 03       Sequestration adjustment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       862, 374       41. 00         41. 00       Interim payments       862, 374       41. 00         42. 00       Tentative settlement (for contractors use only)       42. 01         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00				
39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   39.50	38. 00	MSP-LCC reconciliation amount from PS&R	0	38. 00
39. 75       N95 respirator payment adjustment amount (see instructions)       0       39. 75         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 97         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       892, 942       40. 00         40. 01       Sequestration adjustment (see instructions)       17, 859       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 02       Sequestration adjustment (see instructions)       17, 859       40. 01         40. 02       Sequestration adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment amount after sequestration       862, 374       41. 00         41. 00       Interim payments       862, 374       41. 00         42. 01       Tentative settlement (for contractors use only)       0       42. 01         43. 01       Tentative settlement -PARHM (for contractor use only)       12, 709       43. 00         43. 01       Bal ance due provider/program -PARHM (see instructions) <td< td=""><td></td><td></td><td>0</td><td></td></td<>			0	
39. 97 39. 98 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 892, 942 40. 00 40. 01 Sequestration adjustment (see instructions) 17, 859 40. 01 Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 11. Interim payments 12. 00 42. 01 Tentative settlement (for contractors use only) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 91. 00 0 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 0 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 0 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 0 The rate used to calculate the Time Value of Money 0 0 0. 00 0 92. 00				
Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98				
40.00       Subtotal (see instructions)       892, 942       40.00         40.01       Sequestration adjustment (see instructions)       17,859       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       0       40.03         41.00       Interim payments       862,374       41.00         41.01       Interim payments-PARHM       41.01       41.01         42.01       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       12,709       43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       44.00         70       BE COMPLETED BY CONTRACTOR       0       90.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00				1
40.01       Sequestration adjustment (see instructions)       17,859       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       40.03         41.00       Interim payments       862,374       41.00         41.01       Interim payments-PARHM       41.01       41.01         42.01       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       12,709       43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44.00         5115.2       TO BE COMPLETED BY CONTRACTOR         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00				1
40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       40.03         41.00       Interim payments       862,374       41.00         41.01       Interim payments-PARHM       41.00       41.01         42.00       Tentative settlement (for contractors use only)       0       42.01         43.00       Balance due provider/program (see instructions)       42.01         43.01       Balance due provider/program-PARHM (see instructions)       12,709       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44.00         5115.2       TO BE COMPLETED BY CONTRACTOR       0       44.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00				1
40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   41. 00   Interim payments   41. 00   Interim payments   41. 00   41. 01   42. 00   Tentative settlement (for contractors use only)   42. 01   43. 00   8al ance due provider/program (see instructions)   42. 01   43. 00   8al ance due provider/program (see instructions)   43. 01   44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44. 00   44. 00   44. 00   44. 00   44. 00   67. 00				1
41.00		, , , , , , , , , , , , , , , , , , , ,		1
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  0 42.00 42.01 43.00 43.01 44.00 45.01 46.02 47.02 47.03 47.04 47.04 47.04 48.00 49.00 49.00	41.00	1 '	862, 374	41. 00
42.01 43.00 43.01 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0utlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money  42.01 42.01 43.00 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 91.00 90.00 91.00 91.00 92.00				
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  12, 709 43.00 43.01 44.00 91.00 90.00 91.00 92.00			0	1
43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  10 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  43.01 44.00 45.01 47.01 49.00 49.00 49.00 49.00 49.00		, , , , , , , , , , , , , , , , , , , ,	12 709	1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f		, , , , , , , , , , , , , , , , , , , ,	12,707	1
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  70.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0.00 92.00				1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0.00 92.00	90 00		0	90 00
92.00 The rate used to calculate the Time Value of Money 0.00 92.00		, ,		
93.00  Time Value of Money (see instructions)   0   93.00	92.00	The rate used to calculate the Time Value of Money	0.00	92. 00
	93. 00	Time Value of Money (see instructions)	0	93. 00

Health Financial Systems	FRANCISCAN BEACON	I HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0191	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	epared:
				5/24/2024 10:	48 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Provider CCN: 15-0191

Title XVIII	48 am
Total interim payments paid to provider   1.00   2.00   3.00   4.00	
1.00   2.00   3.00   4.00	
1.00   2.00   3.00   4.00	
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 ADJUSTMENTS TO PROVIDER O C C C C C C C C C C C C C C C C C C	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2.00
Write "NONE" or enter a zero   List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   ADJUSTMENTS TO PROVIDER   O   O   O   O   O   O   O   O   O	l
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	l
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  ADJUSTMENTS TO PROVIDER  3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.07 3.08 3.09 3.09 4.00 4.00 5.01 3.52 3.54 3.99 5.00 5.00 5.00 1.00 5.00 1.00 5.00 5.00	1
for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  3.01 ADJUSTMENTS TO PROVIDER  0 0 0 3.02 3.03 3.04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00
Dayment	l
Program to Provider	l
3. 01   ADJUSTMENTS TO PROVIDER	
3. 02 3. 03 3. 04 3. 05 Provider to Program  ADJUSTMENTS TO PROGRAM  O  State of the program of	200
3. 03 3. 04 3. 05 3. 06 3. 07 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5. 01 5. 02 5. 03 Provider to Program 5. 50 TENTATIVE TO PROGRAM	
3.04   0   0   0   0   0   0   0   0   0	3. 02
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.50   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98 minus sum of lines 3.50-3.	
Provider to Program   3.50   ADJUSTMENTS TO PROGRAM   0   0   0   0   0   0   0   0   0	3. 04 3. 05
3.50   ADJUSTMENTS TO PROGRAM	3.05
3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 50
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02 5.03 Provider to Program  TENTATIVE TO PROGRAM  0 CO	
3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02 DO	
3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5. 01 TENTATIVE TO PROVIDER  5. 50 TENTATIVE TO PROGRAM  O CONTRACTOR  O C	3. 53
3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4. 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5. 01 TENTATIVE TO PROVIDER  5. 50 TENTATIVE TO PROGRAM  5. 50 TENTATIVE TO PROGRAM  6 TENTATIVE TO PROGRAM  7 TENTATIVE TO PROGRAM  8 62, 374  8	3. 54
3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  TENTATIVE TO PROVIDER  5.00 Provider to Program  5.50 TENTATIVE TO PROGRAM  O O O O	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02 O	0. //
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02 0 0 0  Provider to Program  5.50 TENTATIVE TO PROGRAM  0 0 0 0  0 0 0 0  0 0 0 0  0 0 0 0  0 0 0 0  0 0	4.00
TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	l
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	
write "NONE" or enter a zero. (1) Program to Provider  5. 01 5. 02 5. 03 Provider to Program  5. 50 TENTATIVE TO PROGRAM  O O O O O O O O O O O O O O O O O O	5.00
Program to Provider	l
5. 01 TENTATI VE TO PROVI DER 0 CC 5. 02 0 CC 5. 03 Provi der to Program 0 CC 5. 50 TENTATI VE TO PROVI DER	1
5. 02	
5. 03 Provi der to Program  5. 50 TENTATI VE TO PROGRAM  0 0 0	
Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0	
5.50 TENTATI VE TO PROGRAM 0 C	5. 03
5. 51 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
5.52   U	5. 99
5. 50-5. 98)	3. 77
6.00 Determined net settlement amount (balance due) based on	6.00
the cost report. (1)	0.00
6. 01 SETTLEMENT TO PROVIDER 4, 911 12, 709	6. 01
6.02 SETTLEMENT TO PROGRAM	6. 02
7.00 Total Medicare program liability (see instructions) 35,476 875,083	
Contractor NPR Date	50
Number (Mo/Day/Yr)	
0 1.00 2.00	
8.00 Name of Contractor	8. 00

Heal th	Financial Systems FRANCISCAN	BEACON HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0191 Period: From 01/01/					1 epared:
	To 12/31/202				
	Title XVIII Hospital				
	TO DE COURTETER BY CONTRACTOR FOR MONOTANDARD COOT REDO	DTO		1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPO				
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCU		. 14		1 00
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (see instructions)					1. 00 2. 00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days (see instructions)	<del>.</del>			4. 00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200					5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, co				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchas		Wkst. S-2. Pt. I		7. 00
	line 168	3,	,		
8.00	Calculation of the HIT incentive payment (see instructi	ons)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestr	ration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instruction	ns)			30. 00
	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instruction	ns)		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 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2024 10:48 am

Medical and other services     0   2.00					5/24/2024 10:	48 am_
PART VII - CALCULATION OF REIMBURSEINENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal	Cost	
PART VII - CALCULATION OF RET INBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				Inpati ent	Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES   39,260   1.00   1					2. 00	
Inpatient hospital/SNE/ME services   39,260   1.00			VICES FOR TITLES V OR XIX	SERVI CES		
Medical and other services   0   2.00						
3.00   Organ acquisition (certified transplant programs only)   3.00   3.00   3.00   5.00   1   1   1   1   1   1   1   1   1	1.00	Inpatient hospital/SNF/NF services		39, 260		1.00
Subtotal (sum of lines 1, 2 and 3)   39,260   0 4,00   0.00   0	2.00	Medical and other services			0	2. 00
Inpatient primary payer payments   0   0   6.00	3.00	Organ acquisition (certified transplant programs only)		0		3. 00
0	4.00	Subtotal (sum of lines 1, 2 and 3)		39, 260	0	4.00
39,260   0   7.00	5.00	Inpatient primary payer payments		0		5.00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   2,729   8.00	6.00	Outpatient primary payer payments			0	6.00
Reasonable Charges   2,779   0   8.00   0.	7.00	Subtotal (line 4 less sum of lines 5 and 6)		39, 260	0	7.00
Reasonable Charges   2,779   0   8.00   0.		COMPUTATION OF LESSER OF COST OR CHARGES				1
8.00   Routine service charges   2,729   8.00   7.00   Anciliary service charges   17,001   0.9   9.00   Anciliary service charges, net of revenue   17,001   0.9   0.00   1.00						1
9.00   Ancillary service charges   17,001   0   9.00     10.00   Organ acquisition charges, net of revenue   0   10.00     10.00   Incentive from target amount computation   19,730   0     200   Total reasonable carges (sum of lines 8 through 11)   19,730   0     201   Total reasonable carges (sum of lines 8 through 11)   19,730   0     202   Marount actually collected from patients liable for payment for services on a charge loss is acharge basis had such payment been made in accordance with 42 CFR \$413.13(e)   0   0   0   0     203   Marount sthat would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)   0   0   0   0   0   0     204   Marount sthat would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)   0   0   0   0   0   0   0   0   0	8.00			2, 729		8.00
10.00   Organ acquisition charges, net of revenue   0   10.0	9.00	,		17, 001	0	9.00
11.00   Incentive from target amount computation   11.00   19.730   0   12.00   20.00   Total reasonable charges (sum of lines 8 through 11)   19.730   0   12.00   20.00						10.00
12.00   Total reasonable charges (sum of lines 8 through 11)   19,730   0   12.00   10,730   0   12.00   10,730   0   12.00   13.00   13.00   14.00   Amount actually collected from patients liable for payment for services on a charge   0   0   13.00   14.00   14.00   14.00   15.00		1 3 1		o		
CUSTOMARY CHARGES				19 730	0	
13.00   Amount actually collected from patients liable for payment for services on a charge   0   0   13.00	12.00			17, 700		12.00
basis     14,00	13 00		services on a charge		0	13 00
Anounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   0.000000   15.00   10.10	13.00		ser vices on a charge	Ĭ	O	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  16.00  17.00  18.00  17.00  18.00  17.00  18.00  18.00  18.00  18.00  19.730  19.730  19.730  10.000000  10.000000  10.000000  10.000000  10.000000  10.000000  10.000000  10.000000  10.000000  10.000000  10.000000  10.0000000  10.0000000  10.00000000	14 00		navment for services on		0	14 00
15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   15.00   19.730   0.000000   15.00   10.000000   15.00   10.000000   15.00   10.000000   15.00   10.0000000   15.00   10.0000000   15.00   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.0000   10.00000   10.00000   10.00000   10.000000   10.00000000   10.0000000000	14.00			Ĭ	O	14.00
16.00   Total customary charges (see instructions)   19,730   0   16.00   17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   0   17.00   17.00   17.00   17.00   18.00   18.00   18.00   18.00   19.530   0   18.00   19.530   0   18.00   19.530   19.00   10.00	15 00		12 OTK 3413. 13(C)	0 000000	0.000000	15 00
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   0   17.00   18.00   19.00   18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line   19,530   0   18.00   16) (see instructions)   0   0   19.00   10.00   16) (see instructions)   0   0   0   19.00   19.00   10.00   19.00   10.00   19.00						
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 19,530   0   18.00   18.00   16) (see instructions)   0   0   10) (see instructions)   0   0   0   0   0   0   0   0   0			v if line 16 exceeds			
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 19,530   0   18.00   16) (see instructions)   0   0   19.00   10.00	17.00		y II IIIIc To exceeds	l	O	17.00
16) (see instructions)	18 00	· · · · · · · · · · · · · · · · · · ·	vifline / evceeds line	10 530	0	18 00
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   20.00	10.00		y II IIIIe 4 exceeds IIIIe	17, 550	O	10.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   19,730   0   20.00	10 00				0	10 00
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   19,730   0   21.00			cuctions)			
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				-	-	
22.00       Other than outlier payments       0       0       22.00         23.00       Outlier payments       0       0       23.00         24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       25.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00       0         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       0       19,730       0       28.00         29.00       Computation of Relimbursement Settlement       0       19,730       0       30.00       30.00       31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       19,730       0       31.00       31.00       32.00       32.00       33.00       0       31.00       32.00       33.00       0       33.00       0       33.00       0       33.00       0       34.00       34.00       34.00       34.00       35.00       0       34.00       35.00       0       34.00 <td>21.00</td> <td></td> <td></td> <td></td> <td>0</td> <td>21.00</td>	21.00				0	21.00
23.00       Outlier payments       0       0       23.00         24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       19,730       0       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       19,730       0       31.00         32.00       Deductibles       0       0       32.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       35.00         35.00       Utilization review       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       19,730       0       36.00         38.00       Direct graduate med	22 00		compreted for FF3 provide		0	22 00
24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       19,730       0       29.00         COMPUTATION OF REI MBURSEMENT SETTLEMENT         30.00       Excess of reasonable cost (from line 18)       19,530       0       30.00         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       19,730       0       31.00         32.00       Deductibles       0       0       32.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Utilization review       0       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       19,730       0       36.00						
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  31.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 31.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Bal ance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  52.00 Capital exception payments (set 10.00 pc. p. 25.00 pc.				i	U	
26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 26.00 Customary charges (title V or XIX PDS covered services only) 0 17.00 17.00 17.00 0 17.0				١		
27. 00 Subtotal (sum of lines 22 through 26) 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 0 29. 00  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 19, 530 0 31. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 19, 730 0 31. 00 32. 00 Deductibles 0 0 0 32. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 19, 730 0 36. 00 38. 00 Subtotal (line 36 ± line 37) 19, 730 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 19, 730 0 40. 00 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 13, 239 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00				١	0	
28.00 Customary charges (title V or XIX PPS covered services only)  70				١		
29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 30. 00 Coinsurance 30. 01 Oinsurance 31. 00 Oinsurance 32. 00 Allowable bad debts (see instructions) 33. 00 Villization review 34. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  9 0 0 30. 00				<u>۱</u>		
30.00   Excess of reasonable cost (from line 18)   19,530   0 30.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   19,730   0 31.00   32.00   20						
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29.00			19, 730	0	29.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  33.00 Coinsurance  34.00 Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	20.00			10 520	0	20.00
32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 19, 730 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 19, 730 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 19, 730 0 40. 00 41. 00 Interim payments 6, 491 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) 13, 239 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00						
33.00   Coinsurance   0   0   33.00   34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Utilization review   0   35.00   36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   19,730   0   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   37.00   38.00   Subtotal (line 36 ± line 37)   19,730   0   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   19,730   0   41.00   Interim payments   6,491   0   42.00   Balance due provider/program (line 40 minus line 41)   13,239   0   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00						
34. 00   Allowable bad debts (see instructions)				ı	-	
35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 19,730 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 19,730 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 0 70 0 0 39.00 Total amount payable to the provider (sum of lines 38 and 39) 19,730 0 40.00 Interim payments 6,491 0 41.00 Interim payments 6,491 0 41.00 Balance due provider/program (line 40 minus line 41) 13,239 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0	_	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  36.00  36.00  36.00  37.00  37.00  37.00  37.00  39.00  49.70  39.00  40.00  40.00  41.00  42.00  43.00		,		0	0	
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 37.00  37.00  37.00  37.00  37.00  38.00  38.00  39.00  40.00  40.00  41.00  42.00  43.00				0		
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  19,730 0 38.00 39.00 40.00 41.00 41.00 42.00 43.00			1 33)	19, 730		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 40.00 41.00 41.00 42.00 43.00				0		
40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 40.00  41.00  42.00  43.00		,		19, 730	0	
41.00 Interim payments 6, 491 0 41.00 Balance due provider/program (line 40 minus line 41) 13, 239 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00		, , , , , , , , , , , , , , , , , , , ,				
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00		1 3				
		, , , , , , , , , , , , , , , , , , , ,				
chapter 1, §115.2	43.00	,	nce with CMS Pub 15-2,	0	0	43. 00
		chapter 1, §115.2				1

Heal th	Financial Systems FRANCI	SCAN BEACON	HOSPI TAL	In Lie	u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT			Provider CCN: 15-0191	Peri od: Worksheet E-		
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 10:4	
Title XVIII					PPS	
					1. 00	
TO BE COMPLETED BY CONTRACTOR						
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				0	1.00	
2.00 Capital outlier from Wkst. L, Pt. I, line 2			0	2.00		
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00	
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00	
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00		
6.00 Time value of money for operating expenses (see instructions)				0	6.00	
7.00 Time value of money for capital related expenses (see instructions)				0	7.00	

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

Date/Time Prepared: 5/24/2024 10:48 am

——————————————————————————————————————					5/24/2024 10:	48 am_
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS		1			
1.00	Cash on hand in banks	2, 225, 812	1	0	_	
2. 00 3. 00	Temporary investments Notes receivable		0	0	0	2. 00 3. 00
4.00	Accounts receivable	4, 113, 203	· ·	0	0	
5. 00	Other recei vabl e	0	Ō	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-2, 941, 709	0	0	0	
7.00	Inventory	167, 834	1	0	0	
8.00	Prepaid expenses	364, 786	1	0	0 0	
9. 00 10. 00	Other current assets Due from other funds	-1, 277	0	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	3, 928, 649	1	0		11.00
	FI XED ASSETS					1
12.00	Land	1, 514, 351	0	0	0	12. 00
13.00	Land improvements	42, 865	1	0		13. 00
14.00	Accumulated depreciation	-15, 003	1	0	1	14. 00
15. 00 16. 00	Buildings Accumulated depreciation	18, 857, 743 -1, 731, 906	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	-1, 731, 700	0	0	0	17. 00
18. 00	Accumulated depreciation		ő	0	o o	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	0	0	21. 00
22. 00	Accumulated depreciation	4 ((4 044	0	0	0	22. 00
23. 00 24. 00	Major movable equipment Accumulated depreciation	4, 664, 044 -2, 811, 860	1	0	0	23. 00 24. 00
25. 00	Mi nor equi pment depreci abl e	-2,811,800	0	0	0	25. 00
26. 00	Accumul ated depreciation		ő	0	o o	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	00 500 004	0	0	-	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	20, 520, 234	0	0	0	30.00
31. 00	Investments		0	0	0	31.00
32. 00	Deposits on Leases	0	Ō	0		32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	0	0		0	34. 00
35. 00	Total other assets (sum of lines 31-34)	0 000	0	0		35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	24, 448, 883	0	0	0	36. 00
37. 00	Accounts payable	223, 449	0	0	0	37. 00
38. 00	Sal ari es, wages, and fees payable	346, 112	1	0		38. 00
39. 00	Payroll taxes payable	43, 395	0	0	0	
40.00	Notes and Loans payable (short term)	0	0	0	0	
41.00	Deferred income	63, 764	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	11, 318, 719	0	0	0	42. 00 43. 00
44. 00	Other current liabilities	11, 310, 717	Ö	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	11, 995, 439	0	0		1
	LONG TERM LIABILITIES	,				
46. 00	Mortgage payable	0	0	0	-	
47. 00	Notes payable		0	0	1	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities		0	0		48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)		ő	_		
51. 00	Total liabilities (sum of lines 45 and 50)	11, 995, 439	1			51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	12, 453, 444	1			52. 00
53.00	Specific purpose fund		0			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance		•	0		56.00
57. 00	Plant fund balance - invested in plant			O	0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				Ö	58. 00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	12, 453, 444	1	0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	24, 448, 883	0	0	0	60.00
	<i>∨′</i> /	I	I		I	I

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0191

Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/24/2024 10:48 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 14, 718, 012 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -2, 264, 572 2.00 3.00 Total (sum of line 1 and line 2) 12, 453, 440 0 3.00 4.00 ROUNDI NG 0 0 4.00 4 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 12, 453, 444 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 12, 453, 444 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 ROUNDI NG 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00 Health Financial Systems FISTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0191

Cost Center Description         Inpatient         Outpatient         Total           1.00         2.00         3.00   PART I - PATIENT REVENUES	10: 48 am
PART I - PATIENT REVENUES 1.00 2.00 3.00	
PART I - PATIENT REVENUES	
Company I manti ant Daviti no Compiled	
General Inpatient Routine Services	
	, 240 1. 00
2.00 SUBPROVIDER - IPF	2. 00
3. 00 SUBPROVIDER - I RF	3. 00
4. 00 SUBPROVI DER	4. 00
5.00 Swing bed - SNF	0 5.00
6.00 Swing bed - NF	0 6.00
7.00 SKILLED NURSING FACILITY	7. 00
8.00 NURSING FACILITY	8.00
9. OO OTHER LONG TERM CARE	9. 00
	, 240 10. 00
Intensive Care Type Inpatient Hospital Services	7 2 10 10.00
11. 00   INTENSIVE CARE UNIT	11, 00
12. OO CORONARY CARE UNIT	12.00
13. 00 BURN INTENSIVE CARE UNIT	13. 00
14. 00 SURGICAL INTENSIVE CARE UNIT	14. 00
15. 00 OTHER SPECIAL CARE (SPECIFY)	15. 00
16.00 Total intensive care type inpatient hospital services (sum of lines 0	0 16.00
11-15)	0 10.00
	, 240 17. 00
18. 00   Ancillary services   116, 322   25, 527, 513   25, 643	
19. 00   Outpatient services   10, 522   25, 527, 513   25, 64, 19, 00   Outpatient services   30, 526   10, 599, 804   10, 630	
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 HOSPICE	26.00
27. 00 OTHER (SPECIFY) 0 0 0	0 27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 179,088 36,127,317 36,300	, 405 28. 00
G-3, line 1)	
PART II - OPERATING EXPENSES	20.00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 11, 250, 583	29. 00
30. 00   ADD (SPECIFY) 0	30.00
31.00	31.00
32. 00	32. 00
33. 00	33. 00
34. 00	34.00
35. 00	35. 00
36.00 Total additions (sum of lines 30-35)	36. 00
37. 00   DEDUCT (SPECIFY) 0	37. 00
38.00	38. 00
39.00	39. 00
40.00	40. 00
41.00	41. 00
42.00 Total deductions (sum of lines 37-41)	42. 00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 11,250,583	43. 00
to Wkst. G-3, line 4)	I

Health Financial Systems FRANCISCAN BEACON HOSPITAL In Lieu of Form CMS-2552-10					
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0191 Period:			Worksheet G-3		
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 10:4	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			36, 306, 405	
2.00	Less contractual allowances and discounts on patients' ac	counts		27, 462, 790	
3.00	Net patient revenues (line 1 minus line 2)			8, 843, 615	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		11, 250, 583	•
5. 00	Net income from service to patients (line 3 minus line 4)			-2, 406, 968	5. 00
	OTHER I NCOME			_	
6. 00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			32, 200	1
8. 00	Revenues from telephone and other miscellaneous communica	tion services		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			17	
11. 00	Rebates and refunds of expenses			32, 268	1
12. 00	Parking lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters				15. 00
	Revenue from sale of medical and surgical supplies to oth	er than patients			16. 00
	Revenue from sale of drugs to other than patients				17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE AND UNCOLLECTIBLE ACCT			77, 911	24. 00
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (sum of lines 6-24)			142, 396	25. 00
26.00	Total (line 5 plus line 25)			-2, 264, 572	26. 00
	OTHER EXPENSES (SPECIFY)			0	1
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 2	8)		-2, 264, 572	29 00

Heal th	Financial Systems FRANCISCAN BEACO	ON HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0191	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/24/2024 10:	
Title XVIII Hospital					
				4.00	
	DADT I FULLY DROCDECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			2, 793	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier				1. 01
2. 00	Capital DRG outlier payments			0	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	0. 04	
4.00	Number of interns & residents (see instructions)		,	0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6. 00
	1.01)(see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	E, part A line	0. 00	7. 00
0.00	30) (see instructions)	+:>		0.00	0.00
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instru Sum of lines 7 and 8	ictions)		0. 00 0. 00	
10.00		-)		0.00	
11. 00				0.00	11.00
12.00				2, 793	
12.00	prospective capital payments (see thisti detrons)			2,770	12.00
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00				0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				4.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)	,		0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see ir	nstructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 >	(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appli			0	
10.00	Current year comparison of capital minimum payment level to c			0	
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital pa	avments (line 10 plus lir	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over of			0	
	(if line 12 is negative, enter the amount on this line)				
15. 00	Current year allowable operating and capital payment (see ins	structions)		0	15. 00
16.00				0	16. 00
17.00	Current year exception offset amount (see instructions)			0	17. 00