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COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 06/02/2014 TIME: 16:57 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [ ] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED	6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY FRANCISCAN ST. JAMES HEALTH (14-0172) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		2,306,183	269,479	-387,307	2,459,906	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		-124,667				3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		2,181,516	269,479	-387,307	2,459,906	200

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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS

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PARTS I, II & III

INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER
THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:										
1	STREET: 20201 SOUTH CRAWFORD AVE	P.O. BOX:								1
2	CITY: OLYMPIA FIELDS	STATE: IL	ZIP CODE: 60461		COUNTY: COOK					2
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:										
							PAYMENT SYSTEM (P, T, O, OR N)			
	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	FRANCISCAN ST. JAMES HEALTH	14-0172	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF	FRANCISCAN ST. JAMES HEALTH REHAB	14-T172	16974	5	07/01/1985	N	P	O	5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	FRANCISCAN ST. JAMES HEALTH HHA	14-7267	16974		05/24/1984	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013							20
21	TYPE OF CONTROL (see instructions)	4								21

INPATIENT PPS INFORMATION		1	2
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	Y	N
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)	N	Y
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	1	N

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	6,203	4,135		53	3,588		24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	157	76			90		25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1	26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.	1	27

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	38

		1	2	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
	OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM 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 AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
		1	2	3	4	
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)						
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)					62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)					62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS						
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	Y				63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				8.05	54.29	0.129131	64
	ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. 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)							
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65		INTERNAL MEDICINE	1400	3.84	15.54	0.198142	65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				8.05	54.29	0.129131	66
	ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. 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)							
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
INPATIENT PSYCHIATRIC FACILITY PPS				1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.							71
INPATIENT REHABILITATION FACILITY PPS				1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				Y	N		76

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WORKSHEET S-2
PART I

LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			86

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

				V	XIX	
TITLE V AND XIX SERVICES				1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS				1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N		108
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	Y	Y	Y	N	109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	N				115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			1		118
		PREMIUMS		PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		121
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.			N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					132

133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y		140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

		TITLE XVIII				
		PART A	PART B	TITLE V	TITLE XIX	
			1	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N		N	157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.		166

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS	
	0	1	2	3	4	5	

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00		169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	09/01/2013	11/29/2013	170

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y			5
		Y/N	Y/N		
APPROVED EDUCATIONAL ACTIVITIES		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA		1	2	3	4
16	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)	N		N		16
17	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
18	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 THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	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
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES. ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35

		Y/N	DATE	
HOME OFFICE COSTS		1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?			36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			37
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.			38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.			39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.			40

COST REORT PREPARER INFORMATION				
41	FIRST NAME: MICHAEL	LAST NAME: CADDICK	TITLE: VICE PRESIDENT	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.			42
43	PHONE NUMBER: 708 466-7240	E-MAIL ADDRESS: MICHAEL.CADDICK@SRINC.ORG		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	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)	30	244	97,151			28,776	6,954	52,334	1
2	HMO AND OTHER (see instructions)						2,976	3,641		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER						138	90		4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		244	97,151			28,776	6,954	52,334	7
8	INTENSIVE CARE UNIT	31	45	16,425			4,270	539	7,487	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						2,602	2,899	13
14	TOTAL (see instructions)		289	113,576			33,046	10,095	62,720	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41	30	10,950			3,278	233	4,329	17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					24,176		33,226	22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		319							27
28	OBSERVATION BED DAYS								7,185	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							243	318	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	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)					7,128	2,108	15,989	1
2	HMO AND OTHER (see instructions)								2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)	85.85	1,527.08			7,128	2,108	15,989	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF	0.98	23.78			235	13	371	17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		28.82						22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)	86.83	1,579.68						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	92,192,142	1,182	92,193,324	3,291,966.00	28.01	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE		294,931		294,931	2,562.00	115.12	4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21	2,415,541		2,415,541	92,023.00	26.25	7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)		3,619,857		3,619,857	88,230.00	41.03	7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		6,960,365	-349,720	6,610,645	222,804.00	29.67	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		11,188,446		11,188,446	227,608.00	49.16	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		274,350		274,350	2,126.00	129.05	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		15,324,404		15,324,404	243,243.00	63.00	14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		21,949,797		21,949,797			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		1,538,377		1,538,377			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE		53,510		53,510			22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)		637,519		637,519			25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		451,279		451,279	41,499.00	10.87	26
27	ADMINISTRATIVE & GENERAL		12,873,365	-171,339	12,702,026	434,216.00	29.25	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		234,759		234,759	835.00	281.15	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		3,610,588		3,610,588	147,921.00	24.41	30
31	LAUNDRY & LINEN SERVICE		203,605		203,605	13,271.00	15.34	31
32	HOUSEKEEPING		2,031,344		2,031,344	158,991.00	12.78	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		2,269,445	-1,527,362	742,083	50,447.00	14.71	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			1,519,019	1,519,019	103,263.00	14.71	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,371,311		1,371,311	30,747.00	44.60	38
39	CENTRAL SERVICES AND SUPPLY		674,136		674,136	41,878.00	16.10	39
40	PHARMACY		2,092,828		2,092,828	59,298.00	35.29	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		1,733,004		1,733,004	78,842.00	21.98	41
42	SOCIAL SERVICE			530,584	530,584	17,059.00	31.10	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		86,391,503	1,182	86,392,685	3,112,548.00	27.76	1
2	EXCLUDED AREA SALARIES (see instructions)		6,960,365	-349,720	6,610,645	222,804.00	29.67	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		79,431,138	350,902	79,782,040	2,889,744.00	27.61	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		26,787,200		26,787,200	472,977.00	56.64	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		22,003,307		22,003,307		27.58%	5

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		128,221,645	350,902	128,572,547	3,362,721.00	38.23	6
7	TOTAL OVERHEAD COST (see instructions)		27,545,664	350,902	27,896,566	1,178,267.00	23.68	7

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HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	24,931	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	5,994,825	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	8,417,617	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	1,168,748	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	37,120	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	229,124	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	861,882	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	7,026,214	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	297,405	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	121,337	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	24,179,203	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	6,617,597	165,464	1
2	HOSPITAL	6,617,597	165,464	2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7267** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA COUNTY:

		TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
	DESCRIPTION	1	2	3	4	5	
1	HOME HEALTH AIDE HOURS		8,024		1,714	9,738	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		1,051.00		773.00	1,832.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF	CONTRACT	TOTAL	
		1	2	3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.00		1.00	3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	4.83		4.83	5
6	DIRECT NURSING SERVICE	17.12		17.12	6
7	NURSING SUPERVISOR	1.56		1.56	7
8	PHYSICAL THERAPY SERVICE		7.94	7.94	8
9	PHYSICAL THERAPY SUPERVISOR	0.73		0.73	9
10	OCCUPATIONAL THERAPY SERVICE		2.54	2.54	10
11	OCCUPATIONAL THERAPY SUPERVISOR	0.23		0.23	11
12	SPEECH PATHOLOGY SERVICE	0.08	0.22	0.30	12
13	SPEECH PATHOLOGY SUPERVISOR	0.03		0.03	13
14	MEDICAL SOCIAL SERVICE		0.17	0.17	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	4.79		4.79	16
17	HOME HEALTH AIDE SUPERVISOR	0.44		0.44	17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	16974	20

PPS ACTIVITY

		FULL EPISODES					
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES	TOTAL (columns 1 through 4)	
		1	2	3	4	5	
21	SKILLED NURSING VISITS	10,967	466	479	99	12,011	21
22	SKILLED NURSING VISIT CHARGES	1,959,154	85,840	76,220	17,020	2,138,234	22
23	PHYSICAL THERAPY VISITS	5,730	21	31	52	5,834	23
24	PHYSICAL THERAPY VISIT CHARGES	1,077,110	3,990	5,700	9,690	1,096,490	24
25	OCCUPATIONAL THERAPY VISITS	1,838	1	4	15	1,858	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	335,960	185	740	2,775	339,660	26
27	SPEECH PATHOLOGY VISITS	190	8	1		199	27
28	SPEECH PATHOLOGY VISIT CHARGES	35,150	1,480	185		36,815	28
29	MEDICAL SOCIAL SERVICE VISITS	133	4		1	138	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	31,255	940		235	32,430	30
31	HOME HEALTH AIDE VISITS	3,861	195	7	73	4,136	31
32	HOME HEALTH AIDE VISIT CHARGES	403,305	20,370	735	7,455	431,865	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	22,719	695	522	240	24,176	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	3,841,934	112,805	83,580	37,175	4,075,494	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	1,250		156	21	1,427	36
37	TOTAL NUMBER OF OUTLIER EPISODES		9			9	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	158,951	28,219	3,744	1,042	191,956	38

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.245434	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	37,924,733	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	160,931,833	6
7	MEDICAID COST (line 1 times line 6)	39,498,144	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	1,573,411	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	1,573,411	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	40,351,649		40,351,649	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	9,903,667		9,903,667	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	2,380,756		2,380,756	22
23	COST OF CHARITY CARE (line 21 minus line 22)	7,522,911		7,522,911	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	13,613,969	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	2,509,836	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	11,104,133	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	2,725,332	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	10,248,243	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	11,821,654	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		6,384,146	6,384,146	6,521,065	12,905,211	-11,459,412	1,445,799	1
2	00200	CAP REL COSTS-MVBLE EQUIP		4,542,026	4,542,026	2,593,998	7,136,024	11,221	7,147,245	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	451,279	-4,044,847	-3,593,568	4,399,678	806,110	-7,862	798,248	4
5	00500	ADMINISTRATIVE & GENERAL	12,873,365	68,372,640	81,246,005	-6,811,430	74,434,575	-19,571,939	54,862,636	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	3,610,588	8,962,820	12,573,408	-25,395	12,548,013	-537,587	12,010,426	7
8	00800	LAUNDRY & LINEN SERVICE	203,605	2,225,792	2,429,397		2,429,397		2,429,397	8
9	00900	HOUSEKEEPING	2,031,344	2,119,513	4,150,857	-22,270	4,128,587	-182	4,128,405	9
10	01000	DIETARY	2,269,445	1,717,604	3,987,049	-2,691,887	1,295,162	-269,489	1,025,673	10
11	01100	CAFETERIA				2,668,672	2,668,672	-1,110,996	1,557,676	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,371,311	798,490	2,169,801	-319,667	1,850,134	542,785	2,392,919	13
14	01400	CENTRAL SERVICES & SUPPLY	674,136	3,162,947	3,837,083	-2,710,018	1,127,065	-198,531	928,534	14
15	01500	PHARMACY	2,092,828	16,802,979	18,895,807	-15,302,974	3,592,833	-454,404	3,138,429	15
16	01600	MEDICAL RECORDS & LIBRARY	1,733,004	1,136,145	2,869,149		2,869,149	-9,796	2,859,353	16
17	01700	SOCIAL SERVICE				679,147	679,147		679,147	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,415,541	5,368,205	7,783,746	-5,368,205	2,415,541		2,415,541	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				5,368,205	5,368,205	-400,565	4,967,640	22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
23.01	02301	RADIOLOGY PARAMEDICAL								23.01
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	20,720,315	7,594,017	28,314,332	-932,022	27,382,310	-426,051	26,956,259	30
31	03100	INTENSIVE CARE UNIT	5,767,816	2,438,958	8,206,774	31,794	8,238,568	-10,696	8,227,872	31
41	04100	SUBPROVIDER - IRF	1,477,053	503,479	1,980,532	31,794	2,012,326	-9,218	2,003,108	41
43	04300	NURSERY				1,355,650	1,355,650		1,355,650	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	4,681,911	12,981,261	17,663,172	-4,681,520	12,981,652	-1,766,702	11,214,950	50
50.01	05001	SURGICENTER	106,578	1,747,580	1,854,158	-1,138,080	716,078	1,374,426	2,090,504	50.01
50.02	05002	SURGERY RECOVERY CENTER		2,020,337	2,020,337	-207,280	1,813,057		1,813,057	50.02
51	05100	RECOVERY ROOM	1,370,159	265,164	1,635,323		1,635,323		1,635,323	51
53	05300	ANESTHESIOLOGY	17,396	8,247,099	8,264,495		8,264,495	-7,859,680	404,815	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,860,318	994,254	3,854,572	-322,367	3,532,205	-171,620	3,360,585	54
54.01	05401	BREAST DIAGNOSIS CENTER	834,025	556,098	1,390,123	145,039	1,535,162	-1,498	1,533,664	54.01
55	05500	RADIOLOGY-THERAPEUTIC	952,681	752,954	1,705,635		1,705,635		1,705,635	55
56	05600	RADIOISOTOPE	556,745	740,661	1,297,406	52,347	1,349,753		1,349,753	56
57	05700	CT SCAN	848,425	889,335	1,737,760	93,328	1,831,088		1,831,088	57
58	05800	MRI	565,827	568,842	1,134,669	46,770	1,181,439	-21,403	1,160,036	58
59	05900	CARDIAC CATHETERIZATION	1,603,561	4,877,992	6,481,553	-2,276,747	4,204,806	-3,603	4,201,203	59
60	06000	LABORATORY		10,370,087	10,370,087	45,000	10,415,087	-40,365	10,374,722	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	2,187,464	1,084,064	3,271,528	3,239	3,274,767	-7,322	3,267,445	65
65.01	06501	SLEEP LAB	239,309	85,122	324,431	6,879	331,310	-3,101	328,209	65.01
66	06600	PHYSICAL THERAPY	47,069	1,925,605	1,972,674		1,972,674		1,972,674	66
66.01	06601	OP PHYSICAL THERAPY		1,005,391	1,005,391		1,005,391		1,005,391	66.01
66.02	06602	OP THERAPY SERVICES		2,885,957	2,885,957	-279,801	2,606,156		2,606,156	66.02
67	06700	OCCUPATIONAL THERAPY		1,056,322	1,056,322		1,056,322		1,056,322	67
68	06800	SPEECH PATHOLOGY	341,069	118,281	459,350		459,350		459,350	68
69	06900	ELECTROCARDIOLOGY	1,210,912	553,990	1,764,902	-299,799	1,465,103	-38,511	1,426,592	69
69.01	06901	EP LAB	81,093	413,602	494,695	11,849	506,544		506,544	69.01
69.02	03650	VASCULAR SERVICES	234,439	74,226	308,665	21,419	330,084		330,084	69.02
70	07000	ELECTROENCEPHALOGRAPHY	85,026	36,794	121,820		121,820		121,820	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				2,710,018	2,710,018		2,710,018	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				7,156,150	7,156,150		7,156,150	72
73	07300	DRUGS CHARGED TO PATIENTS				15,302,974	15,302,974		15,302,974	73
74	07400	RENAL DIALYSIS		918,057	918,057		918,057		918,057	74
75	07500	ASC (NON-DISTINCT PART)	1,287,141	288,750	1,575,891		1,575,891		1,575,891	75
76	03951	WOUND CARE								76
76.01	03952	OP ONCOLOGY	631,413	234,147	865,560		865,560		865,560	76.01

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
76.97	07697	CARDIAC REHABILITATION	658,763	202,023	860,786	17,761	878,547	-1,522	877,025	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	DIABETES CENTER								90.01
91	09100	EMERGENCY	7,615,876	3,145,165	10,761,041	539,753	11,300,794	-539,668	10,761,126	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	HOME HEALTH AGENCY	2,541,526	1,970,398	4,511,924	-487,606	4,024,318		4,024,318	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		6,098,508	6,098,508	-6,098,508				113
116	11600	HOSPICE	167,477	112,087	279,564		279,564		279,564	116
118		SUBTOTALS (sum of lines 1-117)	89,417,833	195,305,067	284,722,900	-173,047	284,549,853	-42,993,291	241,556,562	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-1,182	350,891	349,709		349,709		349,709	190
191	19100	RESEARCH	47,034	13,170	60,204		60,204		60,204	191
192	19200	PHYSICIANS' PRIVATE OFFICES	2,703,307	6,759,085	9,462,392	158,389	9,620,781	-3,551,397	6,069,384	192
193	19300	NONPAID WORKERS		11,067	11,067	14,658	25,725		25,725	193
194	07950	DEVELOPMENT	25,150	33,920	59,070		59,070	286	59,356	194
194.01	07951	SENIOR FRIENDS								194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS								194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS								194.03
200		TOTAL (sum of lines 118-199)	92,192,142	202,473,200	294,665,342		294,665,342	-46,544,402	248,120,940	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RENT/LEASE EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		260,099	1
2			CAP REL COSTS-MVBLE EQUIP	2		2,593,998	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
500	TOTAL RECLASSIFICATIONS					2,854,097	500
	CODE LETTER - A						
1	INTERNS RESIDENTS NON SALARY	B	I&R SERVICES-OTHER PRGM COSTS	22		5,368,205	1
500	TOTAL RECLASSIFICATIONS					5,368,205	500
	CODE LETTER - B						
1	COST OF CHARGEABLE MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		2,710,018	1
500	TOTAL RECLASSIFICATIONS					2,710,018	500
	CODE LETTER - C						
1	COST OF DRUGS SOLD	D	DRUGS CHARGED TO PATIENTS	73		15,302,974	1
500	TOTAL RECLASSIFICATIONS					15,302,974	500
	CODE LETTER - D						
1	SOCIAL SERVICES	E	SOCIAL SERVICE	17	530,584	148,563	1
500	TOTAL RECLASSIFICATIONS				530,584	148,563	500
	CODE LETTER - E						
1	INTEREST	F	CAP REL COSTS-BLDG & FIXT	1		6,158,774	1
2							2
3							3
4							4
5							5
500	TOTAL RECLASSIFICATIONS					6,158,774	500
	CODE LETTER - F						
1	CAFETERIA COSTS	G	CAFETERIA	11	1,519,019	1,149,653	1
2			NONPAID WORKERS	193	8,343	6,315	2
500	TOTAL RECLASSIFICATIONS				1,527,362	1,155,968	500
	CODE LETTER - G						
1	RADIOLOGY ADMIN COSTS	H	BREAST DIAGNOSIS CENTER	54.01	101,141	28,319	1
2			MRI	58	61,520	17,226	2
3			CT SCAN	57	80,784	22,620	3
4			RADIOISOTOPE	56	40,896	11,451	4
500	TOTAL RECLASSIFICATIONS				284,341	79,616	500
	CODE LETTER - H						
1	PROFESSIONAL FEES	I	OPERATING ROOM	50		48,000	1
2			RADIOLOGY-DIAGNOSTIC	54		41,590	2
3			LABORATORY	60		45,000	3
500	TOTAL RECLASSIFICATIONS					134,590	500
	CODE LETTER - I						
1	HHA OVERHEAD COSTS	J	ADMINISTRATIVE & GENERAL	5	359,245	100,589	1
500	TOTAL RECLASSIFICATIONS				359,245	100,589	500
	CODE LETTER - J						
1	PROPERTY INSURANCE	K	CAP REL COSTS-BLDG & FIXT	1		242,882	1
500	TOTAL RECLASSIFICATIONS					242,882	500
	CODE LETTER - K						
1	NURSERY COSTS	L	NURSERY	43	983,735	371,915	1
500	TOTAL RECLASSIFICATIONS				983,735	371,915	500
	CODE LETTER - L						

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DIRECTOR FEES	M	ADULTS & PEDIATRICS	30		103,961	1
2			INTENSIVE CARE UNIT	31		31,794	2
3			SUBPROVIDER - IRF	41		31,794	3
4			OPERATING ROOM	50		644,856	4
5			ELECTROCARDIOLOGY	69		101,063	5
6			SLEEP LAB	65.01		10,598	6
7			BREAST DIAGNOSIS CENTER	54.01		15,579	7
8			EMERGENCY	91		539,753	8
9			RESPIRATORY THERAPY	65		8,611	9
500	TOTAL RECLASSIFICATIONS					1,488,009	500
	CODE LETTER - M						
1	CARDIAC ADMIN	N	CARDIAC CATHETERIZATION	59	193,532	146,301	1
2			EP LAB	69.01	6,748	5,101	2
3			VASCULAR SERVICES	69.02	12,198	9,221	3
4			CARDIAC REHABILITATION	76.97	10,115	7,646	4
500	TOTAL RECLASSIFICATIONS				222,593	168,269	500
	CODE LETTER - N						
1	EXCESS ALLOCATINO OF EMPLOYEE BENEF	O	EMPLOYEE BENEFITS DEPARTMENT	4		3,537,796	1
500	TOTAL RECLASSIFICATIONS					3,537,796	500
	CODE LETTER - O						
1	EMPLOYEE BENEFITS ALLOCATIONS	P	EMPLOYEE BENEFITS DEPARTMENT	4		861,882	1
500	TOTAL RECLASSIFICATIONS					861,882	500
	CODE LETTER - P						
1	AMBULANCE COSTS	Q	ADULTS & PEDIATRICS	30		319,667	1
500	TOTAL RECLASSIFICATIONS					319,667	500
	CODE LETTER - Q						
1	SALARY CREDITS	R	GIFT, FLOWER, COFFEE SHOP & C	190	1,182		1
500	TOTAL RECLASSIFICATIONS				1,182		500
	CODE LETTER - R						
1	CHICAGO HEIGHTS POB COSTS	S	PHYSICIANS' PRIVATE OFFICES	192		158,389	1
2							2
500	TOTAL RECLASSIFICATIONS					158,389	500
	CODE LETTER - S						
1	IMPLANT SUPPLY COSTS	T	IMPL. DEV. CHARGED TO PATIENT	72		7,156,150	1
2							2
500	TOTAL RECLASSIFICATIONS					7,156,150	500
	CODE LETTER - T						
	GRAND TOTAL (INCREASES)				3,909,042	48,318,353	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RENT/LEASE EXPENSE	A	ADMINISTRATIVE & GENERAL	5		326,958	9	1
2			OPERATION OF PLANT	7		7,696	9	2
3			HOUSEKEEPING	9		22,270		3
4			DIETARY	10		8,557		4
5			OPERATING ROOM	50		787,668		5
6			SURGICENTER	50.01		1,138,080		6
7			SURGERY RECOVERY CENTER	50.02		207,280		7
8			MRI	58		31,976		8
9			RESPIRATORY THERAPY	65		4,066		9
10			SLEEP LAB	65.01		3,719		10
11			OP THERAPY SERVICES	66.02		279,801		11
12			ELECTROCARDIOLOGY	69		10,000		12
13			HOME HEALTH AGENCY	101		26,026		13
500	TOTAL RECLASSIFICATIONS					2,854,097		500
	CODE LETTER - A							
1	INTERNS RESIDENTS NON SALARY	B	I&R SERVICES-SALARY & FRINGES	21		5,368,205		1
500	TOTAL RECLASSIFICATIONS					5,368,205		500
	CODE LETTER - B							
1	COST OF CHARGEABLE MEDICAL SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		2,710,018		1
500	TOTAL RECLASSIFICATIONS					2,710,018		500
	CODE LETTER - C							
1	COST OF DRUGS SOLD	D	PHARMACY	15		15,302,974		1
500	TOTAL RECLASSIFICATIONS					15,302,974		500
	CODE LETTER - D							
1	SOCIAL SERVICES	E	ADMINISTRATIVE & GENERAL	5	530,584	148,563		1
500	TOTAL RECLASSIFICATIONS				530,584	148,563		500
	CODE LETTER - E							
1	INTEREST	F	INTEREST EXPENSE	113		6,098,508	9	1
2			OPERATING ROOM	50		47,138		2
3			CT SCAN	57		10,076		3
4			RESPIRATORY THERAPY	65		1,306		4
5			HOME HEALTH AGENCY	101		1,746		5
500	TOTAL RECLASSIFICATIONS					6,158,774		500
	CODE LETTER - F							
1	CAFETERIA COSTS	G	DIETARY	10	1,527,362	1,155,968		1
2								2
500	TOTAL RECLASSIFICATIONS				1,527,362	1,155,968		500
	CODE LETTER - G							
1	RADIOLOGY ADMIN COSTS	H	RADIOLOGY-DIAGNOSTIC	54	284,341	79,616		1
2								2
3								3
4								4
500	TOTAL RECLASSIFICATIONS				284,341	79,616		500
	CODE LETTER - H							
1	PROFESSIONAL FEES	I	ADMINISTRATIVE & GENERAL	5		134,590		1
2								2
3								3
500	TOTAL RECLASSIFICATIONS					134,590		500
	CODE LETTER - I							
1	HHA OVERHEAD COSTS	J	HOME HEALTH AGENCY	101	359,245	100,589		1
500	TOTAL RECLASSIFICATIONS				359,245	100,589		500
	CODE LETTER - J							
1	PROPERTY INSURANCE	K	ADMINISTRATIVE & GENERAL	5		242,882	9	1
500	TOTAL RECLASSIFICATIONS					242,882		500
	CODE LETTER - K							
1	NURSERY COSTS	L	ADULTS & PEDIATRICS	30	983,735	371,915		1
500	TOTAL RECLASSIFICATIONS				983,735	371,915		500
	CODE LETTER - L							

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DIRECTOR FEES	M	ADMINISTRATIVE & GENERAL	5		1,488,009		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
500	TOTAL RECLASSIFICATIONS					1,488,009		500
	CODE LETTER - M							
1	CARDIAC ADMIN	N	ELECTROCARDIOLOGY	69	222,593	168,269		1
2								2
3								3
4								4
500	TOTAL RECLASSIFICATIONS				222,593	168,269		500
	CODE LETTER - N							
1	EXCESS ALLOCATINO OF EMPLOYEE BENEF	O	ADMINISTRATIVE & GENERAL	5		3,537,796		1
500	TOTAL RECLASSIFICATIONS					3,537,796		500
	CODE LETTER - O							
1	EMPLOYEE BENEFITS ALLOCATIONS	P	ADMINISTRATIVE & GENERAL	5		861,882		1
500	TOTAL RECLASSIFICATIONS					861,882		500
	CODE LETTER - P							
1	AMBULANCE COSTS	Q	NURSING ADMINISTRATION	13		319,667		1
500	TOTAL RECLASSIFICATIONS					319,667		500
	CODE LETTER - Q							
1	SALARY CREDITS	R	GIFT, FLOWER, COFFEE SHOP & C	190		1,182		1
500	TOTAL RECLASSIFICATIONS					1,182		500
	CODE LETTER - R							
1	CHICAGO HEIGHTS POB COSTS	S	CAP REL COSTS-BLDG & FIXT	1		140,690	9	1
2			OPERATION OF PLANT	7		17,699		2
500	TOTAL RECLASSIFICATIONS					158,389		500
	CODE LETTER - S							
1	IMPLANT SUPPLY COSTS	T	OPERATING ROOM	50		4,539,570		1
2			CARDIAC CATHETERIZATION	59		2,616,580		2
500	TOTAL RECLASSIFICATIONS					7,156,150		500
	CODE LETTER - T							
	GRAND TOTAL (DECREASES)				3,907,860	48,319,535		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	7,320,500					7,320,500		1
2	LAND IMPROVEMENTS	4,107,924	103,214		103,214	276,425	3,934,713		2
3	BUILDINGS AND FIXTURES	90,996,275	23,302,266		23,302,266		114,298,541		3
4	BUILDING IMPROVEMENTS		1,075,647		1,075,647		1,075,647		4
5	FIXED EQUIPMENT	89,909,898	10,937,984		10,937,984	10,608,285	90,239,597		5
6	MOVABLE EQUIPMENT	74,633,511	5,725,190		5,725,190	1,766,162	78,592,539		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	266,968,108	41,144,301		41,144,301	12,650,872	295,461,537		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	266,968,108	41,144,301		41,144,301	12,650,872	295,461,537		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	6,384,146						6,384,146	1
2	CAP REL COSTS-MVBLE EQUIP	4,542,026						4,542,026	2
3	TOTAL (sum of lines 1-2)	10,926,172						10,926,172	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,445,799						1,445,799	1
2	CAP REL COSTS-MVBLE EQUIP	7,147,245						7,147,245	2
3	TOTAL (sum of lines 1-2)	8,593,044						8,593,044	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,
Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-1,292,033	CAP REL COSTS-BLDG & FIXT	1	9	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)	B	-133,877	ADMINISTRATIVE & GENERAL	5		5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-12,201,973				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-6,712,281				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,110,996	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-198,531	CENTRAL SERVICES & SUPPLY	14		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-333,169	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-9,796	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-27,327	DIETARY	10		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES	A	-479,865	CAP REL COSTS-BLDG & FIXT	1	9	26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	14,694	CAP REL COSTS-MVBLE EQUIP	2	9	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
33.15	PATIENT PHONE COSTS	A	-184,478	ADMINISTRATIVE & GENERAL	5		33.15
33.17	PATIENT TV COSTS	A	-3,473	CAP REL COSTS-MVBLE EQUIP	2	9	33.17
33.18	PATIENT TV COSTS/REPAIRS	A	-6,395	ADMINISTRATIVE & GENERAL	5		33.18
33.19	PROPERTY TAXES	A	-418,000	OPERATION OF PLANT	7		33.19
33.44	PHYSICIAN FEES	A	-3,551,397	PHYSICIANS' PRIVATE OFFICES	192		33.44
33.45	1500 FEES	A	-158,731	ADMINISTRATIVE & GENERAL	5		33.45
33.61	MARKETING COSTS	A	-1,686,423	ADMINISTRATIVE & GENERAL	5		33.61
33.62	ELIMINATE NEGATIVE EXPENSES	A	286	DEVELOPMENT	194		33.62
33.73	PRINT SHOP FEES	B	-72	ADMINISTRATIVE & GENERAL	5		33.73
33.75	DIABETES COST	A	-724,041	ADMINISTRATIVE & GENERAL	5		33.75
33.76	WRITE OFF PHYSICIANS LOANS	A	-47,500	ADMINISTRATIVE & GENERAL	5		33.76
33.78	TELECOMMUNICATIONS REVENUE	B	-85,653	ADMINISTRATIVE & GENERAL	5		33.78
33.79	BABY PHOTOS	B	-1,450	ADULTS & PEDIATRICS	30		33.79
33.82	RADIOLOGY PROGRAM FEES	B	-80,904	RADIOLOGY-DIAGNOSTIC	54		33.82
33.84	DONATIONS	A	-57,138	ADMINISTRATIVE & GENERAL	5		33.84
33.85	PARKING REVENUES	B	-79,572	OPERATION OF PLANT	7		33.85
33.87	NON-ALLOWABLE ADMIN EXPENSES	A	-42,804	ADMINISTRATIVE & GENERAL	5		33.87
33.89	INTEREST EXPENSE	A	-1,054,677	CAP REL COSTS-BLDG & FIXT	1	9	33.89
33.91	CRNA FEES/SALARIES	A	-155,502	ANESTHESIOLOGY	53		33.91
33.95	EMPLOYEE BADGES	B	-619	OPERATION OF PLANT	7		33.95
33.98	SPECIAL FUNCTION MEALS	B	-14,616	DIETARY	10		33.98
34	OTHER REVENUE	B	-9,180	ELECTROCARDIOLOGY	69		34
34.01	DIETARY DISCOUNTS/REBATES	B	-227,546	DIETARY	10		34.01

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
34.08	RENTAL REVENUE	B	-16,846	CAP REL COSTS-BLDG & FIXT	1	9	34.08
34.09	DISCOUNTS/REBATES	B	-31,595	OPERATION OF PLANT	7		34.09
34.10	MISC REVENUE	B	-7,801	OPERATION OF PLANT	7		34.10
34.17	RESEARCH COSTS	A	-182,092	OPERATING ROOM	50		34.17
35	MEDICAID TAX	A	-14,577,002	ADMINISTRATIVE & GENERAL	5		35
35.12	EMT REVENUE	B	-7,862	EMPLOYEE BENEFITS DEPARTMENT	4		35.12
35.13	CASHIERING REVENUE	B	-30,772	ADMINISTRATIVE & GENERAL	5		35.13
35.14	MISC REVENUE	B	-1,425	ADULTS & PEDIATRICS	30		35.14
35.15	MISC REVENUE	B	-3,603	CARDIAC CATHETERIZATION	59		35.15
35.16	LOBBYING COSTS	A	-334,897	ADMINISTRATIVE & GENERAL	5		35.16
36	MISC REVENUE	B	-182	HOUSEKEEPING	9		36
37	DISCOUNTS/REBATES	B	-253,187	OPERATING ROOM	50		37
38	DISCOUNTS/REBATES	B	-17,254	LABORATORY	60		38
39	DISCOUNTS/REBATES	B	-4,845	RESPIRATORY THERAPY	65		39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-46,544,402				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	1	CAP REL COSTS-BLDG & FIXT	INTEREST	2,855,170	6,098,508	-3,243,338	9	1
2	15	PHARMACY	HOME OFFICE PHARMACY COST	726,364	857,542	-131,178		2
3	5	ADMINISTRATIVE & GENERAL	ADMIN/INFO SVCS	25,543,788	25,757,884	-214,096		3
3.01	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE INTEREST INCO		-24,721	24,721	9	3.01
3.02	13	NURSING ADMINISTRATION	AMBULANCE SERVICE	319,667	342,818	-23,151		3.02
4	50.01	SURGICENTER	RELATED PARTY EXPENSES	6,217,659	4,500,000	1,717,659		4
4.01	1	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	3,081,887	8,479,261	-5,397,374	9	4.01
4.03	58	MRI	MRI PURCHASED SERVICES	172,093	193,496	-21,403		4.03
4.04	13	NURSING ADMINISTRATION	AMBULANCE SERVICES	1,117,344	551,408	565,936		4.04
4.05	15	PHARMACY	CORPORATE ALLOCATION	723,379	713,436	9,943		4.05
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			40,757,351	47,469,632	-6,712,281		5

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

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B			SISTERS OF ST. FRANCIS HEALTH	100.00	HOSP MGMT	6
7	B	SURBURBAN HEIGHTS MEDICAL CENT	100.00				7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GEN AGGREGATE	1,569,589	1,269,882	299,707	154,100	3,800	281,529	14,076	1
2	30	ADULTS & PEDIATRICS AGGREGATE	468,961	394,775	74,186	154,100	618	45,785	2,289	2
3	31	INTENSIVE CARE UNIT AGGREGATE	31,794		31,794	165,600	265	21,098	1,055	3
4	41	SUBPROVIDER - IRF AGGREGATE	31,794		31,794	177,200	265	22,576	1,129	4
5	50	OPERATING ROOM AGGREGATE	1,331,523		1,331,523	208,000	1	100	5	5
6	54.01	BREAST DIAGNOSIS CEN AGGREGATE	15,579		15,579	225,300	130	14,081	704	6
7	54	RADIOLOGY-DIAGNOSTIC AGGREGATE	90,716	90,716		225,300				7
8	60	LABORATORY AGGREGATE	48,000		48,000	215,700	240	24,889	1,244	8
9	50.01	SURGICENTER AGGREGATE	343,333		343,333	208,000	1	100	5	9
10	69	ELECTROCARDIOLOGY AGGREGATE	101,063		101,063	177,200	842	71,732	3,587	10
11	65.01	SLEEP LAB AGGREGATE	10,598		10,598	177,200	88	7,497	375	11
12	22	I&R SERVICES-OTHER P AGGREGATE	400,650		400,650	177,200	1	85	4	12
13	65	RESPIRATORY THERAPY AGGREGATE	8,611		8,611	177,200	72	6,134	307	13
14	76.97	CARDIAC REHABILITATI AGGREGATE	5,100		5,100	177,200	42	3,578	179	14
15	53	ANESTHESIOLOGY AGGREGATE	7,704,178	7,704,178						15
16	91	EMERGENCY AGGREGATE	539,753		539,753	177,200	1	85	4	16
200		TOTAL	12,701,242	9,459,551	3,241,691		6,366	499,269	24,963	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATIO N	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT - ICE INSURANC E	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GEN AGGREGATE					281,529	18,178	1,288,060	1
2	30	ADULTS & PEDIATRICS AGGREGATE					45,785	28,401	423,176	2
3	31	INTENSIVE CARE UNIT AGGREGATE					21,098	10,696	10,696	3
4	41	SUBPROVIDER - IRF AGGREGATE					22,576	9,218	9,218	4
5	50	OPERATING ROOM AGGREGATE					100	1,331,423	1,331,423	5
6	54.01	BREAST DIAGNOSIS CEN AGGREGATE					14,081	1,498	1,498	6
7	54	RADIOLOGY-DIAGNOSTIC AGGREGATE							90,716	7
8	60	LABORATORY AGGREGATE					24,889	23,111	23,111	8
9	50.01	SURGICENTER AGGREGATE					100	343,233	343,233	9
10	69	ELECTROCARDIOLOGY AGGREGATE					71,732	29,331	29,331	10
11	65.01	SLEEP LAB AGGREGATE					7,497	3,101	3,101	11
12	22	I&R SERVICES-OTHER P AGGREGATE					85	400,565	400,565	12
13	65	RESPIRATORY THERAPY AGGREGATE					6,134	2,477	2,477	13
14	76.97	CARDIAC REHABILITATI AGGREGATE					3,578	1,522	1,522	14
15	53	ANESTHESIOLOGY AGGREGATE							7,704,178	15
16	91	EMERGENCY AGGREGATE					85	539,668	539,668	16
200		TOTAL					499,269	2,742,422	12,201,973	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)		3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE		8

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.		

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,445,799	1,445,799					1
2	CAP REL COSTS-MVBLE EQUIP	7,147,245		7,147,245				2
4	EMPLOYEE BENEFITS DEPARTMENT	798,248	22,510	111,275	932,033			4
5	ADMINISTRATIVE & GENERAL	54,862,636	127,889	632,216	129,040	55,751,781	55,751,781	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,010,426	245,038	1,211,325	36,680	13,503,469	3,913,535	7
8	LAUNDRY & LINEN SERVICE	2,429,397	16,560	81,866	2,068	2,529,891	733,205	8
9	HOUSEKEEPING	4,128,405	16,871	83,401	20,636	4,249,313	1,231,523	9
10	DIETARY	1,025,673	14,909	73,704	7,539	1,121,825	325,124	10
11	CAFETERIA	1,557,676	35,291	174,462	15,432	1,782,861	516,703	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,392,919	2,836	14,021	13,931	2,423,707	702,431	13
14	CENTRAL SERVICES & SUPPLY	928,534	39,764	196,574	6,849	1,171,721	339,585	14
15	PHARMACY	3,138,429	9,772	48,310	21,261	3,217,772	932,565	15
16	MEDICAL RECORDS & LIBRARY	2,859,353	15,104	74,666	17,606	2,966,729	859,808	16
17	SOCIAL SERVICE	679,147	1,069	5,285	5,390	690,891	200,232	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	2,415,541	15,275	75,513	24,539	2,530,868	733,489	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,967,640				4,967,640	1,439,707	22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	26,956,259	228,923	1,131,671	200,531	28,517,384	8,264,751	30
31	INTENSIVE CARE UNIT	8,227,872	45,296	223,918	58,595	8,555,681	2,479,582	31
41	SUBPROVIDER - IRF	2,003,108	14,495	71,657	15,005	2,104,265	609,852	41
43	NURSERY	1,355,650	9,023	44,604	9,994	1,419,271	411,329	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,214,950	121,585	601,051	47,564	11,985,150	3,473,500	50
50.01	SURGICENTER	2,090,504			1,083	2,091,587	606,177	50.01
50.02	SURGERY RECOVERY CENTER	1,813,057				1,813,057	525,455	50.02
51	RECOVERY ROOM	1,635,323	191	944	13,919	1,650,377	478,307	51
53	ANESTHESIOLOGY	404,815	9,353	46,236	177	460,581	133,484	53
54	RADIOLOGY-DIAGNOSTIC	3,360,585	61,064	301,867	26,169	3,749,685	1,086,722	54
54.01	BREAST DIAGNOSIS CENTER	1,533,664			9,500	1,543,164	447,235	54.01
55	RADIOLOGY-THERAPEUTIC	1,705,635	30,670	151,617	9,678	1,897,600	549,957	55
56	RADIOISOTOPE	1,349,753	5,242	25,915	6,071	1,386,981	401,971	56
57	CT SCAN	1,831,088	2,213	10,941	9,440	1,853,682	537,229	57
58	MRI	1,160,036			6,373	1,166,409	338,045	58
59	CARDIAC CATHETERIZATION	4,201,203			18,257	4,219,460	1,222,871	59
60	LABORATORY	10,374,722	41,323	204,277		10,620,322	3,077,950	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,267,445	4,987	24,653	22,222	3,319,307	961,992	65
65.01	SLEEP LAB	328,209	3,589	17,744	2,431	351,973	102,008	65.01
66	PHYSICAL THERAPY	1,972,674	11,645	57,566	478	2,042,363	591,912	66
66.01	OP PHYSICAL THERAPY	1,005,391				1,005,391	291,379	66.01
66.02	OP THERAPY SERVICES	2,606,156				2,606,156	755,308	66.02
67	OCCUPATIONAL THERAPY	1,056,322	17,219	85,122		1,158,663	335,800	67
68	SPEECH PATHOLOGY	459,350	270	1,332	3,465	464,417	134,596	68
69	ELECTROCARDIOLOGY	1,426,592	27,254	134,729	10,040	1,598,615	463,306	69
69.01	EP LAB	506,544	10,192	50,383	892	568,011	164,619	69.01
69.02	VASCULAR SERVICES	330,084			2,506	332,590	96,390	69.02
70	ELECTROENCEPHALOGRAPHY	121,820	3,252	16,077	864	142,013	41,158	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,710,018				2,710,018	785,409	71
72	IMPL. DEV. CHARGED TO PATIENTS	7,156,150				7,156,150	2,073,974	72
73	DRUGS CHARGED TO PATIENTS	15,302,974				15,302,974	4,435,062	73
74	RENAL DIALYSIS	918,057				918,057	266,069	74
75	ASC (NON-DISTINCT PART)	1,575,891	55,457	274,151	13,076	1,918,575	556,036	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	865,560	998	4,932	6,415	877,905	254,432	76.01
76.97	CARDIAC REHABILITATION	877,025			6,795	883,820	256,146	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	10,761,126	54,826	271,028	77,370	11,164,350	3,235,618	91

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY	4,024,318			22,170	4,046,488	1,172,741	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	279,564	14,383	71,101	1,701	366,749	106,290	116
118	SUBTOTALS (sum of lines 1-117)	241,556,562	1,336,338	6,606,134	903,752	240,877,709	53,652,569	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	349,709	3,429	16,950		370,088	107,258	190
191	RESEARCH	60,204	11,895	58,801	478	131,378	38,076	191
192	PHYSICIANS' PRIVATE OFFICES	6,069,384	94,137	465,360	27,463	6,656,344	1,929,122	192
193	NONPAID WORKERS	25,725			85	25,810	7,480	193
194	DEVELOPMENT	59,356			255	59,611	17,276	194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	248,120,940	1,445,799	7,147,245	932,033	248,120,940	55,751,781	202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	17,417,004						7
8	LAUNDRY & LINEN SERVICE	274,604	3,537,700					8
9	HOUSEKEEPING	279,754		5,760,590				9
10	DIETARY	247,226		77,788	1,771,963			10
11	CAFETERIA	585,198		184,128		3,068,890		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	47,030		14,798		40,719	3,228,685	13
14	CENTRAL SERVICES & SUPPLY	659,369		207,465		55,460		14
15	PHARMACY	162,045		50,986		78,530		15
16	MEDICAL RECORDS & LIBRARY	250,452		78,803		104,413		16
17	SOCIAL SERVICE	17,729		5,578		22,592		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	253,294		79,697		121,869		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,795,971	2,718,195	1,194,372	1,401,963	927,354	1,486,911	30
31	INTENSIVE CARE UNIT	751,091	386,521	236,325	199,357	205,281	329,146	31
41	SUBPROVIDER - IRF	240,360	223,487	75,627	115,269	65,512	105,042	41
43	NURSERY	149,614		47,075				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,016,109		634,353		218,949	351,062	50
50.01	SURGICENTER					5,277	8,462	50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM	3,167		996		44,475	71,311	51
53	ANESTHESIOLOGY	155,090		48,798		666	1,068	53
54	RADIOLOGY-DIAGNOSTIC	1,012,553		318,592		102,470		54
54.01	BREAST DIAGNOSIS CENTER					47,649		54.01
55	RADIOLOGY-THERAPEUTIC	508,570		160,018		33,177		55
56	RADIOISOTOPE	86,927		27,351		20,264		56
57	CT SCAN	36,701		11,548		39,172		57
58	MRI					28,908		58
59	CARDIAC CATHETERIZATION					59,361		59
60	LABORATORY	685,207		215,595				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	82,695		26,019		98,022	157,167	65
65.01	SLEEP LAB	59,520		18,728		11,858		65.01
66	PHYSICAL THERAPY	193,093		60,755		2,776		66
66.01	OP PHYSICAL THERAPY							66.01
66.02	OP THERAPY SERVICES							66.02
67	OCCUPATIONAL THERAPY	285,525		89,838				67
68	SPEECH PATHOLOGY	4,469		1,406		10,189		68
69	ELECTROCARDIOLOGY	451,921		142,193		44,055	70,638	69
69.01	EP LAB	169,001		53,175		4,048	6,491	69.01
69.02	VASCULAR SERVICES					7,647		69.02
70	ELECTROENCEPHALOGRAPHY	53,926		16,967		5,096	8,171	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)	919,588		289,341		44,353	71,116	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	16,545		5,206		24,238	38,863	76.01
76.97	CARDIAC REHABILITATION					26,073		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	909,111		286,045		326,331	523,237	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
101	HOME HEALTH AGENCY					79,383		101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	238,495	209,497	75,041	55,374	5,345		116
118	SUBTOTALS (sum of lines 1-117)	15,601,950	3,537,700	4,734,607	1,771,963	2,911,512	3,228,685	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,856		17,889		1,103		190
191	RESEARCH	197,236		62,059		1,563		191
192	PHYSICIANS' PRIVATE OFFICES	1,560,962		946,035		153,350		192
193	NONPAID WORKERS					751		193
194	DEVELOPMENT					611		194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	17,417,004	3,537,700	5,760,590	1,771,963	3,068,890	3,228,685	202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	2,433,600						14
15	PHARMACY		4,441,898					15
16	MEDICAL RECORDS & LIBRARY			4,260,205				16
17	SOCIAL SERVICE				937,022			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD					3,719,217		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	419					6,407,766	22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	119,549	13,472	502,079	727,017	3,662,386	6,309,854	30
31	INTENSIVE CARE UNIT	49,780	2,934	103,867	103,380			31
41	SUBPROVIDER - IRF	5,702	293	32,456	59,775	56,831	97,912	41
43	NURSERY			23,276				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	482,709	3,259	318,386				50
50.01	SURGICENTER	22,826	1,121	24,591				50.01
50.02	SURGERY RECOVERY CENTER			27,944				50.02
51	RECOVERY ROOM	1,392	271	50,273				51
53	ANESTHESIOLOGY	33,543	16,451	67,412				53
54	RADIOLOGY-DIAGNOSTIC	9,789	1,422	194,273				54
54.01	BREAST DIAGNOSIS CENTER	20,639	70	40,794				54.01
55	RADIOLOGY-THERAPEUTIC	3,254	188	63,721				55
56	RADIOISOTOPE	49,150	332	70,094				56
57	CT SCAN	19,465	19,892	392,435				57
58	MRI	2,656	16,632	102,839				58
59	CARDIAC CATHETERIZATION	61,461	8,904	232,297				59
60	LABORATORY	114,114		413,131				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	43,253	15,417	113,254				65
65.01	SLEEP LAB	1,170		14,046				65.01
66	PHYSICAL THERAPY	7,494	23	45,608				66
66.01	OP PHYSICAL THERAPY	762	5	23,654				66.01
66.02	OP THERAPY SERVICES	4,056	203	65,163				66.02
67	OCCUPATIONAL THERAPY	2,728		26,208				67
68	SPEECH PATHOLOGY	542		9,906				68
69	ELECTROCARDIOLOGY	1,514	176	108,566				69
69.01	EP LAB	23,876	127	9,331				69.01
69.02	VASCULAR SERVICES	878		16,865				69.02
70	ELECTROENCEPHALOGRAPHY	753		6,356				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	290,525		69,442				71
72	IMPL. DEV. CHARGED TO PATIENTS	885,276		91,786				72
73	DRUGS CHARGED TO PATIENTS	16,859	4,291,020	412,526				73
74	RENAL DIALYSIS	1,197		24,673				74
75	ASC (NON-DISTINCT PART)	4,664	77	20,172				75
76	WOUND CARE							76
76.01	OP ONCOLOGY	3,456	3,699	27,716				76.01
76.97	CARDIAC REHABILITATION	254		13,987				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	85,150	7,731	473,084	46,850			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	17	21	22	
101	HOME HEALTH AGENCY	14,572	401	27,937				101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	4,925	871	57				116
118	SUBTOTALS (sum of lines 1-117)	2,390,352	4,404,991	4,260,205	937,022	3,719,217	6,407,766	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,694						190
191	RESEARCH							191
192	PHYSICIANS' PRIVATE OFFICES	8,553	36,907					192
193	NONPAID WORKERS	1						193
194	DEVELOPMENT							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,433,600	4,441,898	4,260,205	937,022	3,719,217	6,407,766	202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	59,641,258	-9,972,240	49,669,018				30
31	INTENSIVE CARE UNIT	13,402,945		13,402,945				31
41	SUBPROVIDER - IRF	3,792,383	-154,743	3,637,640				41
43	NURSERY	2,050,565		2,050,565				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	19,483,477		19,483,477				50
50.01	SURGICENTER	2,760,041		2,760,041				50.01
50.02	SURGERY RECOVERY CENTER	2,366,456		2,366,456				50.02
51	RECOVERY ROOM	2,300,569		2,300,569				51
53	ANESTHESIOLOGY	917,093		917,093				53
54	RADIOLOGY-DIAGNOSTIC	6,475,506		6,475,506				54
54.01	BREAST DIAGNOSIS CENTER	2,099,551		2,099,551				54.01
55	RADIOLOGY-THERAPEUTIC	3,216,485		3,216,485				55
56	RADIOISOTOPE	2,043,070		2,043,070				56
57	CT SCAN	2,910,124		2,910,124				57
58	MRI	1,655,489		1,655,489				58
59	CARDIAC CATHETERIZATION	5,804,354		5,804,354				59
60	LABORATORY	15,126,319		15,126,319				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,817,126		4,817,126				65
65.01	SLEEP LAB	559,303		559,303				65.01
66	PHYSICAL THERAPY	2,944,024		2,944,024				66
66.01	OP PHYSICAL THERAPY	1,321,191		1,321,191				66.01
66.02	OP THERAPY SERVICES	3,430,886		3,430,886				66.02
67	OCCUPATIONAL THERAPY	1,898,762		1,898,762				67
68	SPEECH PATHOLOGY	625,525		625,525				68
69	ELECTROCARDIOLOGY	2,880,984		2,880,984				69
69.01	EP LAB	998,679		998,679				69.01
69.02	VASCULAR SERVICES	454,370		454,370				69.02
70	ELECTROENCEPHALOGRAPHY	274,440		274,440				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,855,394		3,855,394				71
72	IMPL. DEV. CHARGED TO PATIENTS	10,207,186		10,207,186				72
73	DRUGS CHARGED TO PATIENTS	24,458,441		24,458,441				73
74	RENAL DIALYSIS	1,209,996		1,209,996				74
75	ASC (NON-DISTINCT PART)	3,823,922		3,823,922				75
76	WOUND CARE							76
76.01	OP ONCOLOGY	1,252,060		1,252,060				76.01
76.97	CARDIAC REHABILITATION	1,180,280		1,180,280				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	17,057,507		17,057,507				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
101	HOME HEALTH AGENCY	5,341,522		5,341,522				101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	1,062,644		1,062,644				116
118	SUBTOTALS (sum of lines 1-117)	235,699,927	-10,126,983	225,572,944				118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	587,888		587,888				190
191	RESEARCH	430,312		430,312				191
192	PHYSICIANS' PRIVATE OFFICES	11,291,273		11,291,273				192
193	NONPAID WORKERS	34,042		34,042				193
194	DEVELOPMENT	77,498		77,498				194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	248,120,940	-10,126,983	237,993,957				202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		22,510	111,275	133,785	133,785		4
5	ADMINISTRATIVE & GENERAL	2,677,628	127,889	632,216	3,437,733	18,520	3,456,253	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		245,038	1,211,325	1,456,363	5,264	242,617	7
8	LAUNDRY & LINEN SERVICE		16,560	81,866	98,426	297	45,455	8
9	HOUSEKEEPING		16,871	83,401	100,272	2,962	76,347	9
10	DIETARY		14,909	73,704	88,613	1,082	20,156	10
11	CAFETERIA		35,291	174,462	209,753	2,215	32,033	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,836	14,021	16,857	1,999	43,547	13
14	CENTRAL SERVICES & SUPPLY		39,764	196,574	236,338	983	21,052	14
15	PHARMACY		9,772	48,310	58,082	3,051	57,814	15
16	MEDICAL RECORDS & LIBRARY		15,104	74,666	89,770	2,527	53,303	16
17	SOCIAL SERVICE		1,069	5,285	6,354	774	12,413	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		15,275	75,513	90,788	3,522	45,472	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						89,254	22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		228,923	1,131,671	1,360,594	28,800	512,327	30
31	INTENSIVE CARE UNIT		45,296	223,918	269,214	8,409	153,720	31
41	SUBPROVIDER - IRF		14,495	71,657	86,152	2,154	37,807	41
43	NURSERY		9,023	44,604	53,627	1,434	25,500	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		121,585	601,051	722,636	6,826	215,337	50
50.01	SURGICENTER					155	37,580	50.01
50.02	SURGERY RECOVERY CENTER						32,575	50.02
51	RECOVERY ROOM		191	944	1,135	1,998	29,652	51
53	ANESTHESIOLOGY		9,353	46,236	55,589	25	8,275	53
54	RADIOLOGY-DIAGNOSTIC		61,064	301,867	362,931	3,756	67,371	54
54.01	BREAST DIAGNOSIS CENTER					1,363	27,726	54.01
55	RADIOLOGY-THERAPEUTIC		30,670	151,617	182,287	1,389	34,094	55
56	RADIOISOTOPE		5,242	25,915	31,157	871	24,920	56
57	CT SCAN		2,213	10,941	13,154	1,355	33,305	57
58	MRI					915	20,957	58
59	CARDIAC CATHETERIZATION					2,620	75,811	59
60	LABORATORY		41,323	204,277	245,600		190,815	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		4,987	24,653	29,640	3,189	59,638	65
65.01	SLEEP LAB		3,589	17,744	21,333	349	6,324	65.01
66	PHYSICAL THERAPY		11,645	57,566	69,211	69	36,695	66
66.01	OP PHYSICAL THERAPY						18,064	66.01
66.02	OP THERAPY SERVICES						46,825	66.02
67	OCCUPATIONAL THERAPY		17,219	85,122	102,341		20,818	67
68	SPEECH PATHOLOGY		270	1,332	1,602	497	8,344	68
69	ELECTROCARDIOLOGY		27,254	134,729	161,983	1,441	28,722	69
69.01	EP LAB		10,192	50,383	60,575	128	10,205	69.01
69.02	VASCULAR SERVICES					360	5,976	69.02
70	ELECTROENCEPHALOGRAPHY		3,252	16,077	19,329	124	2,552	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						48,691	71
72	IMPL. DEV. CHARGED TO PATIENTS						128,575	72
73	DRUGS CHARGED TO PATIENTS						274,949	73
74	RENAL DIALYSIS						16,495	74
75	ASC (NON-DISTINCT PART)		55,457	274,151	329,608	1,877	34,471	75
76	WOUND CARE							76
76.01	OP ONCOLOGY		998	4,932	5,930	921	15,773	76.01
76.97	CARDIAC REHABILITATION					975	15,880	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY		54,826	271,028	325,854	11,104	200,590	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY					3,182	72,703	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE		14,383	71,101	85,484	244	6,589	116
118	SUBTOTALS (sum of lines 1-117)	2,677,628	1,336,338	6,606,134	10,620,100	129,726	3,326,114	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,429	16,950	20,379		6,649	190
191	RESEARCH		11,895	58,801	70,696	69	2,360	191
192	PHYSICIANS' PRIVATE OFFICES		94,137	465,360	559,497	3,941	119,595	192
193	NONPAID WORKERS					12	464	193
194	DEVELOPMENT					37	1,071	194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,677,628	1,445,799	7,147,245	11,270,672	133,785	3,456,253	202

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,704,244						7
8	LAUNDRY & LINEN SERVICE	26,870	171,048					8
9	HOUSEKEEPING	27,374		206,955				9
10	DIETARY	24,191		2,795	136,837			10
11	CAFETERIA	57,261		6,615		307,877		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	4,602		532		4,085	71,622	13
14	CENTRAL SERVICES & SUPPLY	64,519		7,453		5,564		14
15	PHARMACY	15,856		1,832		7,878		15
16	MEDICAL RECORDS & LIBRARY	24,507		2,831		10,475		16
17	SOCIAL SERVICE	1,735		200		2,266		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	24,785		2,863		12,226		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	371,433	131,425	42,907	108,265	93,036	32,984	30
31	INTENSIVE CARE UNIT	73,494	18,688	8,490	15,395	20,594	7,301	31
41	SUBPROVIDER - IRF	23,519	10,806	2,717	8,901	6,572	2,330	41
43	NURSERY	14,640		1,691				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	197,275		22,790		21,965	7,788	50
50.01	SURGICENTER					529	188	50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM	310		36		4,462	1,582	51
53	ANESTHESIOLOGY	15,175		1,753		67	24	53
54	RADIOLOGY-DIAGNOSTIC	99,078		11,446		10,280		54
54.01	BREAST DIAGNOSIS CENTER					4,780		54.01
55	RADIOLOGY-THERAPEUTIC	49,763		5,749		3,328		55
56	RADIOISOTOPE	8,506		983		2,033		56
57	CT SCAN	3,591		415		3,930		57
58	MRI					2,900		58
59	CARDIAC CATHETERIZATION					5,955		59
60	LABORATORY	67,047		7,745				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	8,092		935		9,834	3,486	65
65.01	SLEEP LAB	5,824		673		1,190		65.01
66	PHYSICAL THERAPY	18,894		2,183		278		66
66.01	OP PHYSICAL THERAPY							66.01
66.02	OP THERAPY SERVICES							66.02
67	OCCUPATIONAL THERAPY	27,938		3,228				67
68	SPEECH PATHOLOGY	437		51		1,022		68
69	ELECTROCARDIOLOGY	44,220		5,108		4,420	1,567	69
69.01	EP LAB	16,537		1,910		406	144	69.01
69.02	VASCULAR SERVICES					767		69.02
70	ELECTROENCEPHALOGRAPHY	5,277		610		511	181	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)	89,981		10,395		4,450	1,578	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	1,619		187		2,432	862	76.01
76.97	CARDIAC REHABILITATION					2,616		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	88,956		10,276		32,738	11,607	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
101	HOME HEALTH AGENCY					7,964		101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	23,337	10,129	2,696	4,276	536		116
118	SUBTOTALS (sum of lines 1-117)	1,526,643	171,048	170,095	136,837	292,089	71,622	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,563		643		111		190
191	RESEARCH	19,299		2,230		157		191
192	PHYSICIANS' PRIVATE OFFICES	152,739		33,987		15,384		192
193	NONPAID WORKERS					75		193
194	DEVELOPMENT					61		194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,704,244	171,048	206,955	136,837	307,877	71,622	202

KPMG LLP

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	335,909						14
15	PHARMACY		144,513					15
16	MEDICAL RECORDS & LIBRARY			183,413				16
17	SOCIAL SERVICE				23,742			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD					179,656		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	58					89,312	22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	16,501	438	21,249	18,421			30
31	INTENSIVE CARE UNIT	6,871	95	4,482	2,619			31
41	SUBPROVIDER - IRF	787	10	1,400	1,515			41
43	NURSERY			1,004				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	66,627	106	13,738				50
50.01	SURGICENTER	3,151	36	1,061				50.01
50.02	SURGERY RECOVERY CENTER			1,206				50.02
51	RECOVERY ROOM	192	9	2,169				51
53	ANESTHESIOLOGY	4,630	535	2,909				53
54	RADIOLOGY-DIAGNOSTIC	1,351	46	8,383				54
54.01	BREAST DIAGNOSIS CENTER	2,849	2	1,760				54.01
55	RADIOLOGY-THERAPEUTIC	449	6	2,750				55
56	RADIOISOTOPE	6,784	11	3,025				56
57	CT SCAN	2,687	647	16,934				57
58	MRI	367	541	4,437				58
59	CARDIAC CATHETERIZATION	8,483	290	10,024				59
60	LABORATORY	15,751		17,827				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,970	502	4,887				65
65.01	SLEEP LAB	161		606				65.01
66	PHYSICAL THERAPY	1,034	1	1,968				66
66.01	OP PHYSICAL THERAPY	105		1,021				66.01
66.02	OP THERAPY SERVICES	560	7	2,812				66.02
67	OCCUPATIONAL THERAPY	377		1,131				67
68	SPEECH PATHOLOGY	75		427				68
69	ELECTROCARDIOLOGY	209	6	4,685				69
69.01	EP LAB	3,296	4	403				69.01
69.02	VASCULAR SERVICES	121		728				69.02
70	ELECTROENCEPHALOGRAPHY	104		274				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,100		2,996				71
72	IMPL. DEV. CHARGED TO PATIENTS	122,197		3,961				72
73	DRUGS CHARGED TO PATIENTS	2,327	139,605	17,800				73
74	RENAL DIALYSIS	165		1,065				74
75	ASC (NON-DISTINCT PART)	644	2	870				75
76	WOUND CARE							76
76.01	OP ONCOLOGY	477	120	1,196				76.01
76.97	CARDIAC REHABILITATION	35		604				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	11,753	252	20,414	1,187			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	
		14	15	16	17	21	22	
101	HOME HEALTH AGENCY	2,011	13	1,205				101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	680	28	2				116
118	SUBTOTALS (sum of lines 1-117)	329,939	143,312	183,413	23,742			118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,789						190
191	RESEARCH							191
192	PHYSICIANS' PRIVATE OFFICES	1,181	1,201					192
193	NONPAID WORKERS							193
194	DEVELOPMENT							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS					179,656	89,312	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	335,909	144,513	183,413	23,742	179,656	89,312	202

KPMG LLP

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,738,380		2,738,380				30
31	INTENSIVE CARE UNIT	589,372		589,372				31
41	SUBPROVIDER - IRF	184,670		184,670				41
43	NURSERY	97,896		97,896				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,275,088		1,275,088				50
50.01	SURGICENTER	42,700		42,700				50.01
50.02	SURGERY RECOVERY CENTER	33,781		33,781				50.02
51	RECOVERY ROOM	41,545		41,545				51
53	ANESTHESIOLOGY	88,982		88,982				53
54	RADIOLOGY-DIAGNOSTIC	564,642		564,642				54
54.01	BREAST DIAGNOSIS CENTER	38,480		38,480				54.01
55	RADIOLOGY-THERAPEUTIC	279,815		279,815				55
56	RADIOISOTOPE	78,290		78,290				56
57	CT SCAN	76,018		76,018				57
58	MRI	30,117		30,117				58
59	CARDIAC CATHETERIZATION	103,183		103,183				59
60	LABORATORY	544,785		544,785				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	126,173		126,173				65
65.01	SLEEP LAB	36,460		36,460				65.01
66	PHYSICAL THERAPY	130,333		130,333				66
66.01	OP PHYSICAL THERAPY	19,190		19,190				66.01
66.02	OP THERAPY SERVICES	50,204		50,204				66.02
67	OCCUPATIONAL THERAPY	155,833		155,833				67
68	SPEECH PATHOLOGY	12,455		12,455				68
69	ELECTROCARDIOLOGY	252,361		252,361				69
69.01	EP LAB	93,608		93,608				69.01
69.02	VASCULAR SERVICES	7,952		7,952				69.02
70	ELECTROENCEPHALOGRAPHY	28,962		28,962				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,787		91,787				71
72	IMPL. DEV. CHARGED TO PATIENTS	254,733		254,733				72
73	DRUGS CHARGED TO PATIENTS	434,681		434,681				73
74	RENAL DIALYSIS	17,725		17,725				74
75	ASC (NON-DISTINCT PART)	473,876		473,876				75
76	WOUND CARE							76
76.01	OP ONCOLOGY	29,517		29,517				76.01
76.97	CARDIAC REHABILITATION	20,110		20,110				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	714,731		714,731				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
101	HOME HEALTH AGENCY	87,078		87,078				101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	134,001		134,001				116
118	SUBTOTALS (sum of lines 1-117)	9,979,514		9,979,514				118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,134		38,134				190
191	RESEARCH	94,811		94,811				191
192	PHYSICIANS' PRIVATE OFFICES	887,525		887,525				192
193	NONPAID WORKERS	551		551				193
194	DEVELOPMENT	1,169		1,169				194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS	268,968		268,968				200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	11,270,672		11,270,672				202

KPMG LLP

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	810,008						1
2	CAP REL COSTS-MVBLE EQUIP		810,008					2
4	EMPLOYEE BENEFITS DEPARTMENT	12,611	12,611	91,742,045				4
5	ADMINISTRATIVE & GENERAL	71,650	71,650	12,702,026	-55,751,781	192,369,159		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	137,281	137,281	3,610,588		13,503,469	588,466	7
8	LAUNDRY & LINEN SERVICE	9,278	9,278	203,605		2,529,891	9,278	8
9	HOUSEKEEPING	9,452	9,452	2,031,344		4,249,313	9,452	9
10	DIETARY	8,353	8,353	742,083		1,121,825	8,353	10
11	CAFETERIA	19,772	19,772	1,519,019		1,782,861	19,772	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,589	1,589	1,371,311		2,423,707	1,589	13
14	CENTRAL SERVICES & SUPPLY	22,278	22,278	674,136		1,171,721	22,278	14
15	PHARMACY	5,475	5,475	2,092,828		3,217,772	5,475	15
16	MEDICAL RECORDS & LIBRARY	8,462	8,462	1,733,004		2,966,729	8,462	16
17	SOCIAL SERVICE	599	599	530,584		690,891	599	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	8,558	8,558	2,415,541		2,530,868	8,558	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					4,967,640		22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	128,254	128,254	19,736,580		28,517,384	128,254	30
31	INTENSIVE CARE UNIT	25,377	25,377	5,767,816		8,555,681	25,377	31
41	SUBPROVIDER - IRF	8,121	8,121	1,477,053		2,104,265	8,121	41
43	NURSERY	5,055	5,055	983,735		1,419,271	5,055	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	68,118	68,118	4,681,911		11,985,150	68,118	50
50.01	SURGICENTER			106,578		2,091,587		50.01
50.02	SURGERY RECOVERY CENTER					1,813,057		50.02
51	RECOVERY ROOM	107	107	1,370,159		1,650,377	107	51
53	ANESTHESIOLOGY	5,240	5,240	17,396		460,581	5,240	53
54	RADIOLOGY-DIAGNOSTIC	34,211	34,211	2,575,977		3,749,685	34,211	54
54.01	BREAST DIAGNOSIS CENTER			935,166		1,543,164		54.01
55	RADIOLOGY-THERAPEUTIC	17,183	17,183	952,681		1,897,600	17,183	55
56	RADIOISOTOPE	2,937	2,937	597,641		1,386,981	2,937	56
57	CT SCAN	1,240	1,240	929,209		1,853,682	1,240	57
58	MRI			627,347		1,166,409		58
59	CARDIAC CATHETERIZATION			1,797,093		4,219,460		59
60	LABORATORY	23,151	23,151			10,620,322	23,151	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,794	2,794	2,187,464		3,319,307	2,794	65
65.01	SLEEP LAB	2,011	2,011	239,309		351,973	2,011	65.01
66	PHYSICAL THERAPY	6,524	6,524	47,069		2,042,363	6,524	66
66.01	OP PHYSICAL THERAPY					1,005,391		66.01
66.02	OP THERAPY SERVICES					2,606,156		66.02
67	OCCUPATIONAL THERAPY	9,647	9,647			1,158,663	9,647	67
68	SPEECH PATHOLOGY	151	151	341,069		464,417	151	68
69	ELECTROCARDIOLOGY	15,269	15,269	988,319		1,598,615	15,269	69
69.01	EP LAB	5,710	5,710	87,841		568,011	5,710	69.01
69.02	VASCULAR SERVICES			246,637		332,590		69.02
70	ELECTROENCEPHALOGRAPHY	1,822	1,822	85,026		142,013	1,822	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					2,710,018		71
72	IMPL. DEV. CHARGED TO PATIENTS					7,156,150		72
73	DRUGS CHARGED TO PATIENTS					15,302,974		73
74	RENAL DIALYSIS					918,057		74
75	ASC (NON-DISTINCT PART)	31,070	31,070	1,287,141		1,918,575	31,070	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	559	559	631,413		877,905	559	76.01
76.97	CARDIAC REHABILITATION			668,878		883,820		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	30,716	30,716	7,615,876		11,164,350	30,716	91

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY			2,182,281		4,046,488		101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	8,058	8,058	167,477		366,749	8,058	116
118	SUBTOTALS (sum of lines 1-117)	748,683	748,683	88,958,211	-55,751,781	185,125,928	527,141	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,921	1,921			370,088	1,921	190
191	RESEARCH	6,664	6,664	47,034		131,378	6,664	191
192	PHYSICIANS' PRIVATE OFFICES	52,740	52,740	2,703,307		6,656,344	52,740	192
193	NONPAID WORKERS			8,343		25,810		193
194	DEVELOPMENT			25,150		59,611		194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,445,799	7,147,245	932,033		55,751,781	17,417,004	202
203	UNIT COST MULT-WS B PT I	1.784919	8.823672	0.010159		0.289817	29.597299	203
204	COST TO BE ALLOC PER B PT II			133,785		3,456,253	1,704,244	204
205	UNIT COST MULT-WS B PT II			0.001458		0.017967	2.896079	205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA PROD FTE'S	NURSING ADMINIS-TRATION NURS DIRECT FTE	CENTRAL SERVICES * SUPPLY COSTED REQUI	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	68,526						8
9	HOUSEKEEPING		618,583					9
10	DIETARY		8,353	389,569				10
11	CAFETERIA		19,772		2,317,312			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		1,589		30,747	1,520,508		13
14	CENTRAL SERVICES & SUPPLY		22,278		41,878		22,700,627	14
15	PHARMACY		5,475		59,298			15
16	MEDICAL RECORDS & LIBRARY		8,462		78,842			16
17	SOCIAL SERVICE		599		17,059			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		8,558		92,023			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						3,910	22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	52,652	128,254	308,224	700,242	700,242	1,115,152	30
31	INTENSIVE CARE UNIT	7,487	25,377	43,829	155,007	155,007	464,350	31
41	SUBPROVIDER - IRF	4,329	8,121	25,342	49,468	49,468	53,184	41
43	NURSERY		5,055					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		68,118		165,328	165,328	4,502,712	50
50.01	SURGICENTER				3,985	3,985	212,917	50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM		107		33,583	33,583	12,985	51
53	ANESTHESIOLOGY		5,240		503	503	312,893	53
54	RADIOLOGY-DIAGNOSTIC		34,211		77,375		91,313	54
54.01	BREAST DIAGNOSIS CENTER				35,980		192,519	54.01
55	RADIOLOGY-THERAPEUTIC		17,183		25,052		30,358	55
56	RADIOISOTOPE		2,937		15,301		458,473	56
57	CT SCAN		1,240		29,579		181,574	57
58	MRI				21,828		24,772	58
59	CARDIAC CATHETERIZATION				44,823		573,307	59
60	LABORATORY		23,151				1,064,453	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		2,794		74,016	74,016	403,464	65
65.01	SLEEP LAB		2,011		8,954		10,912	65.01
66	PHYSICAL THERAPY		6,524		2,096		69,908	66
66.01	OP PHYSICAL THERAPY						7,108	66.01
66.02	OP THERAPY SERVICES						37,836	66.02
67	OCCUPATIONAL THERAPY		9,647				25,446	67
68	SPEECH PATHOLOGY		151		7,694		5,054	68
69	ELECTROCARDIOLOGY		15,269		33,266	33,266	14,120	69
69.01	EP LAB		5,710		3,057	3,057	222,715	69.01
69.02	VASCULAR SERVICES				5,774		8,187	69.02
70	ELECTROENCEPHALOGRAPHY		1,822		3,848	3,848	7,025	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						2,710,018	71
72	IMPL. DEV. CHARGED TO PATIENTS						8,257,856	72
73	DRUGS CHARGED TO PATIENTS						157,263	73
74	RENAL DIALYSIS						11,164	74
75	ASC (NON-DISTINCT PART)		31,070		33,491	33,491	43,504	75
76	WOUND CARE							76
76.01	OP ONCOLOGY		559		18,302	18,302	32,236	76.01
76.97	CARDIAC REHABILITATION				19,688		2,372	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY		30,716		246,412	246,412	794,281	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA PROD FTE'S	NURSING ADMINIS-TRATION NURS DIRECT FTE	CENTRAL SERVICES * SUPPLY COSTED REQUI	
		8	9	10	11	13	14	
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY				59,942		135,924	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	4,058	8,058	12,174	4,036		45,943	116
118	SUBTOTALS (sum of lines 1-117)	68,526	508,411	389,569	2,198,477	1,520,508	22,297,208	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,921		833		323,626	190
191	RESEARCH		6,664		1,180			191
192	PHYSICIANS' PRIVATE OFFICES		101,587		115,794		79,783	192
193	NONPAID WORKERS				567		10	193
194	DEVELOPMENT				461			194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,537,700	5,760,590	1,771,963	3,068,890	3,228,685	2,433,600	202
203	UNIT COST MULT-WS B PT I	51.625660	9.312558	4.548522	1.324332	2.123425	0.107204	203
204	COST TO BE ALLOC PER B PT II	171,048	206,955	136,837	307,877	71,622	335,909	204
205	UNIT COST MULT-WS B PT II	2.496104	0.334563	0.351252	0.132860	0.047104	0.014797	205

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUI	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME		
		15	16	17	21	22		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	15,841,040						15
16	MEDICAL RECORDS & LIBRARY		919,078,905					16
17	SOCIAL SERVICE			67,861				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				187,824			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					187,824		22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	48,044	108,263,675	52,652	184,954	184,954		30
31	INTENSIVE CARE UNIT	10,462	22,409,348	7,487				31
41	SUBPROVIDER - IRF	1,045	7,002,378	4,329	2,870	2,870		41
43	NURSERY		5,021,728					43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,621	68,691,759					50
50.01	SURGICENTER	3,999	5,305,594					50.01
50.02	SURGERY RECOVERY CENTER		6,028,849					50.02
51	RECOVERY ROOM	967	10,846,387					51
53	ANESTHESIOLOGY	58,669	14,544,169					53
54	RADIOLOGY-DIAGNOSTIC	5,071	41,914,431					54
54.01	BREAST DIAGNOSIS CENTER	249	8,801,360					54.01
55	RADIOLOGY-THERAPEUTIC	670	13,747,865					55
56	RADIOISOTOPE	1,183	15,122,699					56
57	CT SCAN	70,940	84,667,846					57
58	MRI	59,316	22,187,421					58
59	CARDIAC CATHETERIZATION	31,755	50,118,073					59
60	LABORATORY		89,132,910					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	54,982	24,434,521					65
65.01	SLEEP LAB		3,030,337					65.01
66	PHYSICAL THERAPY	81	9,839,964					66
66.01	OP PHYSICAL THERAPY	18	5,103,307					66.01
66.02	OP THERAPY SERVICES	723	14,058,880					66.02
67	OCCUPATIONAL THERAPY		5,654,448					67
68	SPEECH PATHOLOGY		2,137,252					68
69	ELECTROCARDIOLOGY	628	23,423,038					69
69.01	EP LAB	452	2,013,067					69.01
69.02	VASCULAR SERVICES		3,638,710					69.02
70	ELECTROENCEPHALOGRAPHY		1,371,365					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		14,982,079					71
72	IMPL. DEV. CHARGED TO PATIENTS		19,802,907					72
73	DRUGS CHARGED TO PATIENTS	15,302,974	89,002,343					73
74	RENAL DIALYSIS		5,323,151					74
75	ASC (NON-DISTINCT PART)	273	4,352,145					75
76	WOUND CARE							76
76.01	OP ONCOLOGY	13,192	5,979,770					76.01
76.97	CARDIAC REHABILITATION		3,017,731					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUI	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME		
		15	16	17	21	22		
91	EMERGENCY	27,570	102,067,715	3,393				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY	1,430	6,027,413					101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	3,106	12,270					116
118	SUBTOTALS (sum of lines 1-117)	15,709,420	919,078,905	67,861	187,824	187,824		118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
191	RESEARCH							191
192	PHYSICIANS' PRIVATE OFFICES	131,620						192
193	NONPAID WORKERS							193
194	DEVELOPMENT							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	4,441,898	4,260,205	937,022	3,719,217	6,407,766		202
203	UNIT COST MULT-WS B PT I	0.280404	0.004635	13.807960	19.801607	34.115800		203
204	COST TO BE ALLOC PER B PT II	144,513	183,413	23,742	179,656	89,312		204
205	UNIT COST MULT-WS B PT II	0.009123	0.000200	0.349862	0.956512	0.475509		205

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	49,669,018		49,669,018	28,401	49,697,419	30
31	INTENSIVE CARE UNIT	13,402,945		13,402,945	10,696	13,413,641	31
41	SUBPROVIDER - IRF	3,637,640		3,637,640	9,218	3,646,858	41
43	NURSERY	2,050,565		2,050,565		2,050,565	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	19,483,477		19,483,477	1,331,423	20,814,900	50
50.01	SURGICENTER	2,760,041		2,760,041	343,233	3,103,274	50.01
50.02	SURGERY RECOVERY CENTER	2,366,456		2,366,456		2,366,456	50.02
51	RECOVERY ROOM	2,300,569		2,300,569		2,300,569	51
53	ANESTHESIOLOGY	917,093		917,093		917,093	53
54	RADIOLOGY-DIAGNOSTIC	6,475,506		6,475,506		6,475,506	54
54.01	BREAST DIAGNOSIS CENTER	2,099,551		2,099,551	1,498	2,101,049	54.01
55	RADIOLOGY-THERAPEUTIC	3,216,485		3,216,485		3,216,485	55
56	RADIOISOTOPE	2,043,070		2,043,070		2,043,070	56
57	CT SCAN	2,910,124		2,910,124		2,910,124	57
58	MRI	1,655,489		1,655,489		1,655,489	58
59	CARDIAC CATHETERIZATION	5,804,354		5,804,354		5,804,354	59
60	LABORATORY	15,126,319		15,126,319	23,111	15,149,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	4,817,126		4,817,126	2,477	4,819,603	65
65.01	SLEEP LAB	559,303		559,303	3,101	562,404	65.01
66	PHYSICAL THERAPY	2,944,024		2,944,024		2,944,024	66
66.01	OP PHYSICAL THERAPY	1,321,191		1,321,191		1,321,191	66.01
66.02	OP THERAPY SERVICES	3,430,886		3,430,886		3,430,886	66.02
67	OCCUPATIONAL THERAPY	1,898,762		1,898,762		1,898,762	67
68	SPEECH PATHOLOGY	625,525		625,525		625,525	68
69	ELECTROCARDIOLOGY	2,880,984		2,880,984	29,331	2,910,315	69
69.01	EP LAB	998,679		998,679		998,679	69.01
69.02	VASCULAR SERVICES	454,370		454,370		454,370	69.02
70	ELECTROENCEPHALOGRAPHY	274,440		274,440		274,440	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,855,394		3,855,394		3,855,394	71
72	IMPL. DEV. CHARGED TO PATIENTS	10,207,186		10,207,186		10,207,186	72
73	DRUGS CHARGED TO PATIENTS	24,458,441		24,458,441		24,458,441	73
74	RENAL DIALYSIS	1,209,996		1,209,996		1,209,996	74
75	ASC (NON-DISTINCT PART)	3,823,922		3,823,922		3,823,922	75
76	WOUND CARE						76
76.01	OP ONCOLOGY	1,252,060		1,252,060		1,252,060	76.01
76.97	CARDIAC REHABILITATION	1,180,280		1,180,280	1,522	1,181,802	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	DIABETES CENTER						90.01
91	EMERGENCY	17,057,507		17,057,507	539,668	17,597,175	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,999,331		5,999,331		5,999,331	92
	OTHER REIMBURSABLE COST CENTERS						
101	HOME HEALTH AGENCY	5,341,522		5,341,522		5,341,522	101
113	INTEREST EXPENSE						113
116	HOSPICE	1,062,644		1,062,644		1,062,644	116
200	SUBTOTAL (SEE INSTRUCTIONS)	231,572,275		231,572,275	2,323,679	233,895,954	200
201	LESS OBSERVATION BEDS	5,999,331		5,999,331		5,999,331	201
202	TOTAL (SEE INSTRUCTIONS)	225,572,944		225,572,944		227,896,623	202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	96,095,276		96,095,276				30
31	INTENSIVE CARE UNIT	22,409,348		22,409,348				31
41	SUBPROVIDER - IRF	7,002,378		7,002,378				41
43	NURSERY	5,021,728		5,021,728				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	27,362,752	41,329,007	68,691,759	0.283636	0.283636	0.303019	50
50.01	SURGICENTER		5,305,594	5,305,594	0.520213	0.520213	0.584906	50.01
50.02	SURGERY RECOVERY CENTER	5,992,321	36,528	6,028,849	0.392522	0.392522	0.392522	50.02
51	RECOVERY ROOM	3,856,192	6,990,195	10,846,387	0.212105	0.212105	0.212105	51
53	ANESTHESIOLOGY	7,041,066	7,503,103	14,544,169	0.063056	0.063056	0.063056	53
54	RADIOLOGY-DIAGNOSTIC	15,559,164	26,355,267	41,914,431	0.154493	0.154493	0.154493	54
54.01	BREAST DIAGNOSIS CENTER	27,039	8,774,321	8,801,360	0.238548	0.238548	0.238719	54.01
55	RADIOLOGY-THERAPEUTIC	773,755	12,974,110	13,747,865	0.233963	0.233963	0.233963	55
56	RADIOISOTOPE	3,985,275	11,137,424	15,122,699	0.135100	0.135100	0.135100	56
57	CT SCAN	31,208,871	53,458,975	84,667,846	0.034371	0.034371	0.034371	57
58	MRI	6,771,197	15,416,224	22,187,421	0.074614	0.074614	0.074614	58
59	CARDIAC CATHETERIZATION	29,862,011	20,256,062	50,118,073	0.115814	0.115814	0.115814	59
60	LABORATORY	52,732,462	36,400,448	89,132,910	0.169705	0.169705	0.169964	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	21,578,148	2,856,373	24,434,521	0.197144	0.197144	0.197246	65
65.01	SLEEP LAB	17,331	3,013,006	3,030,337	0.184568	0.184568	0.185591	65.01
66	PHYSICAL THERAPY	5,907,662	3,932,302	9,839,964	0.299191	0.299191	0.299191	66
66.01	OP PHYSICAL THERAPY	7,167	5,096,140	5,103,307	0.258889	0.258889	0.258889	66.01
66.02	OP THERAPY SERVICES		14,058,880	14,058,880	0.244037	0.244037	0.244037	66.02
67	OCCUPATIONAL THERAPY	4,944,042	710,406	5,654,448	0.335800	0.335800	0.335800	67
68	SPEECH PATHOLOGY	1,871,178	266,074	2,137,252	0.292677	0.292677	0.292677	68
69	ELECTROCARDIOLOGY	11,271,227	12,151,811	23,423,038	0.122998	0.122998	0.124250	69
69.01	EP LAB	1,157,677	855,390	2,013,067	0.496098	0.496098	0.496098	69.01
69.02	VASCULAR SERVICES	1,586,078	2,052,632	3,638,710	0.124871	0.124871	0.124871	69.02
70	ELECTROENCEPHALOGRAPHY	455,996	915,369	1,371,365	0.200122	0.200122	0.200122	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,361,608	4,620,471	14,982,079	0.257334	0.257334	0.257334	71
72	IMPL. DEV. CHARGED TO PATIENTS	14,374,772	5,428,135	19,802,907	0.515439	0.515439	0.515439	72
73	DRUGS CHARGED TO PATIENTS	52,907,273	36,095,070	89,002,343	0.274807	0.274807	0.274807	73
74	RENAL DIALYSIS	5,056,768	266,383	5,323,151	0.227308	0.227308	0.227308	74
75	ASC (NON-DISTINCT PART)	330,181	4,021,964	4,352,145	0.878629	0.878629	0.878629	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	1,389	5,978,381	5,979,770	0.209383	0.209383	0.209383	76.01
76.97	CARDIAC REHABILITATION	936,744	2,080,987	3,017,731	0.391115	0.391115	0.391619	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY	26,547,186	75,520,529	102,067,715	0.167120	0.167120	0.172407	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,688,105	9,480,294	12,168,399	0.493025	0.493025	0.493025	92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY		6,027,413	6,027,413				101
113	INTEREST EXPENSE							113
116	HOSPICE	12,270		12,270				116
200	SUBTOTAL (SEE INSTRUCTIONS)	477,713,637	441,365,268	919,078,905				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	477,713,637	441,365,268	919,078,905				202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[ ] TITLE XIX** **[XX] PPS** **[ ] TEFRA**

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	2,738,380		2,738,380	59,519	46.01	28,776	1,323,984	30
31	INTENSIVE CARE UNIT	589,372		589,372	7,487	78.72	4,270	336,134	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	184,670		184,670	4,329	42.66	3,278	139,839	41
42	SUBPROVIDER I								42
43	NURSERY	97,896		97,896	2,899	33.77			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,610,318		3,610,318	74,234		36,324	1,799,957	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0172** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,275,088	68,691,759	0.018562	13,648,103	253,336	50
50.01	SURGICENTER	42,700	5,305,594	0.008048			50.01
50.02	SURGERY RECOVERY CENTER	33,781	6,028,849	0.005603			50.02
51	RECOVERY ROOM	41,545	10,846,387	0.003830	1,763,493	6,754	51
53	ANESTHESIOLOGY	88,982	14,544,169	0.006118	2,838,637	17,367	53
54	RADIOLOGY-DIAGNOSTIC	564,642	41,914,431	0.013471	8,629,145	116,243	54
54.01	BREAST DIAGNOSIS CENTER	38,480	8,801,360	0.004372	14,633	64	54.01
55	RADIOLOGY-THERAPEUTIC	279,815	13,747,865	0.020353	354,062	7,206	55
56	RADIOISOTOPE	78,290	15,122,699	0.005177	2,225,967	11,524	56
57	CT SCAN	76,018	84,667,846	0.000898	16,089,360	14,448	57
58	MRI	30,117	22,187,421	0.001357	3,122,665	4,237	58
59	CARDIAC CATHETERIZATION	103,183	50,118,073	0.002059	17,033,745	35,072	59
60	LABORATORY	544,785	89,132,910	0.006112	27,388,038	167,396	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,173	24,434,521	0.005164	12,333,017	63,688	65
65.01	SLEEP LAB	36,460	3,030,337	0.012032	9,836	118	65.01
66	PHYSICAL THERAPY	130,333	9,839,964	0.013245	2,164,517	28,669	66
66.01	OP PHYSICAL THERAPY	19,190	5,103,307	0.003760			66.01
66.02	OP THERAPY SERVICES	50,204	14,058,880	0.003571			66.02
67	OCCUPATIONAL THERAPY	155,833	5,654,448	0.027559	1,471,204	40,545	67
68	SPEECH PATHOLOGY	12,455	2,137,252	0.005828	747,614	4,357	68
69	ELECTROCARDIOLOGY	252,361	23,423,038	0.010774	6,603,665	71,148	69
69.01	EP LAB	93,608	2,013,067	0.046500	657,305	30,565	69.01
69.02	VASCULAR SERVICES	7,952	3,638,710	0.002185	1,035,988	2,264	69.02
70	ELECTROENCEPHALOGRAPHY	28,962	1,371,365	0.021119	254,495	5,375	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,787	14,982,079	0.006126	5,114,703	31,333	71
72	IMPL. DEV. CHARGED TO PATIENTS	254,733	19,802,907	0.012863	7,742,613	99,593	72
73	DRUGS CHARGED TO PATIENTS	434,681	89,002,343	0.004884	27,066,512	132,193	73
74	RENAL DIALYSIS	17,725	5,323,151	0.003330	3,439,537	11,454	74
75	ASC (NON-DISTINCT PART)	473,876	4,352,145	0.108883	198,600	21,624	75
76	WOUND CARE						76
76.01	OP ONCOLOGY	29,517	5,979,770	0.004936			76.01
76.97	CARDIAC REHABILITATION	20,110	3,017,731	0.006664			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	DIABETES CENTER						90.01
91	EMERGENCY	714,731	102,067,715	0.007003	13,834,511	96,883	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	330,569	12,168,399	0.027166	1,435,325	38,992	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,478,686	782,510,492		177,217,290	1,312,448	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[ ] TITLE XIX** **[XX] PPS** **[ ] TEFRA**

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: **[ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] PPS [ ] TEFRA**

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	59,519		28,776		30
31	INTENSIVE CARE UNIT	7,487		4,270		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	4,329		3,278		41
42	SUBPROVIDER I					42
43	NURSERY	2,899				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	74,234		36,324		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0172** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	BREAST DIAGNOSIS CENTER							54.01
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
65.01	SLEEP LAB							65.01
66	PHYSICAL THERAPY							66
66.01	OP PHYSICAL THERAPY							66.01
66.02	OP THERAPY SERVICES							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	WOUND CARE							76
76.01	OP ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0172** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	68,691,759			13,648,103		11,896,255		50
50.01	SURGICENTER	5,305,594					1,522,749		50.01
50.02	SURGERY RECOVERY CENTER	6,028,849							50.02
51	RECOVERY ROOM	10,846,387			1,763,493		2,199,995		51
53	ANESTHESIOLOGY	14,544,169			2,838,637		2,293,927		53
54	RADIOLOGY-DIAGNOSTIC	41,914,431			8,629,145		4,647,472		54
54.01	BREAST DIAGNOSIS CENTER	8,801,360			14,633		1,102,415		54.01
55	RADIOLOGY-THERAPEUTIC	13,747,865			354,062		5,881,378		55
56	RADIOISOTOPE	15,122,699			2,225,967		4,945,863		56
57	CT SCAN	84,667,846			16,089,360		13,984,518		57
58	MRI	22,187,421			3,122,665		4,494,819		58
59	CARDIAC CATHETERIZATION	50,118,073			17,033,745		11,211,069		59
60	LABORATORY	89,132,910			27,388,038		1,910,381		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	24,434,521			12,333,017		681,095		65
65.01	SLEEP LAB	3,030,337			9,836		791,390		65.01
66	PHYSICAL THERAPY	9,839,964			2,164,517		4,079		66
66.01	OP PHYSICAL THERAPY	5,103,307							66.01
66.02	OP THERAPY SERVICES	14,058,880					1,016		66.02
67	OCCUPATIONAL THERAPY	5,654,448			1,471,204		1,078		67
68	SPEECH PATHOLOGY	2,137,252			747,614		37		68
69	ELECTROCARDIOLOGY	23,423,038			6,603,665		4,152,380		69
69.01	EP LAB	2,013,067			657,305		500,510		69.01
69.02	VASCULAR SERVICES	3,638,710			1,035,988		863,090		69.02
70	ELECTROENCEPHALOGRAPHY	1,371,365			254,495		258,080		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,982,079			5,114,703		1,241,496		71
72	IMPL. DEV. CHARGED TO PATIENTS	19,802,907			7,742,613		2,613,771		72
73	DRUGS CHARGED TO PATIENTS	89,002,343			27,066,512		14,663,234		73
74	RENAL DIALYSIS	5,323,151			3,439,537		183,426		74
75	ASC (NON-DISTINCT PART)	4,352,145			198,600		1,646,934		75
76	WOUND CARE								76
76.01	OP ONCOLOGY	5,979,770					2,921,150		76.01
76.97	CARDIAC REHABILITATION	3,017,731					1,224,330		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	102,067,715			13,834,511		10,615,824		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,168,399			1,435,325		1,669,158		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	782,510,492			177,217,290		110,122,919		200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0172** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF
[XX] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF
[ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.283636	11,896,255			3,374,206			50
50.01	SURGICENTER	0.520213	1,522,749			792,154			50.01
50.02	SURGERY RECOVERY CENTER	0.392522							50.02
51	RECOVERY ROOM	0.212105	2,199,995			466,630			51
53	ANESTHESIOLOGY	0.063056	2,293,927			144,646			53
54	RADIOLOGY-DIAGNOSTIC	0.154493	4,647,472			718,002			54
54.01	BREAST DIAGNOSIS CENTER	0.238548	1,102,415			262,979			54.01
55	RADIOLOGY-THERAPEUTIC	0.233963	5,881,378			1,376,025			55
56	RADIOISOTOPE	0.135100	4,945,863			668,186			56
57	CT SCAN	0.034371	13,984,518			480,662			57
58	MRI	0.074614	4,494,819			335,376			58
59	CARDIAC CATHETERIZATION	0.115814	11,211,069			1,298,399			59
60	LABORATORY	0.169705	1,910,381			324,201			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.197144	681,095	12,958		134,274	2,555		65
65.01	SLEEP LAB	0.184568	791,390			146,065			65.01
66	PHYSICAL THERAPY	0.299191	4,079			1,220			66
66.01	OP PHYSICAL THERAPY	0.258889							66.01
66.02	OP THERAPY SERVICES	0.244037	1,016			248			66.02
67	OCCUPATIONAL THERAPY	0.335800	1,078			362			67
68	SPEECH PATHOLOGY	0.292677	37			11			68
69	ELECTROCARDIOLOGY	0.122998	4,152,380			510,734			69
69.01	EP LAB	0.496098	500,510			248,302			69.01
69.02	VASCULAR SERVICES	0.124871	863,090			107,775			69.02
70	ELECTROENCEPHALOGRAPHY	0.200122	258,080			51,647			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334	1,241,496			319,479			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439	2,613,771			1,347,240			72
73	DRUGS CHARGED TO PATIENTS	0.274807	14,663,234		32,125	4,029,559		8,828	73
74	RENAL DIALYSIS	0.227308	183,426			41,694			74
75	ASC (NON-DISTINCT PART)	0.878629	1,646,934			1,447,044			75
76	WOUND CARE								76
76.01	OP ONCOLOGY	0.209383	2,921,150			611,639			76.01
76.97	CARDIAC REHABILITATION	0.391115	1,224,330			478,854			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	0.167120	10,615,824			1,774,117			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025	1,669,158			822,937			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		110,122,919	12,958	32,125	22,314,667	2,555	8,828	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		110,122,919	12,958	32,125	22,314,667	2,555	8,828	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T172** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,275,088	68,691,759	0.018562	20,287	377	50
50.01	SURGICENTER	42,700	5,305,594	0.008048			50.01
50.02	SURGERY RECOVERY CENTER	33,781	6,028,849	0.005603			50.02
51	RECOVERY ROOM	41,545	10,846,387	0.003830	26,458	101	51
53	ANESTHESIOLOGY	88,982	14,544,169	0.006118	2,355	14	53
54	RADIOLOGY-DIAGNOSTIC	564,642	41,914,431	0.013471	192,787	2,597	54
54.01	BREAST DIAGNOSIS CENTER	38,480	8,801,360	0.004372			54.01
55	RADIOLOGY-THERAPEUTIC	279,815	13,747,865	0.020353	16,101	328	55
56	RADIOISOTOPE	78,290	15,122,699	0.005177	18,687	97	56
57	CT SCAN	76,018	84,667,846	0.000898	116,808	105	57
58	MRI	30,117	22,187,421	0.001357	23,029	31	58
59	CARDIAC CATHETERIZATION	103,183	50,118,073	0.002059			59
60	LABORATORY	544,785	89,132,910	0.006112	751,610	4,594	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,173	24,434,521	0.005164	280,444	1,448	65
65.01	SLEEP LAB	36,460	3,030,337	0.012032			65.01
66	PHYSICAL THERAPY	130,333	9,839,964	0.013245	1,969,749	26,089	66
66.01	OP PHYSICAL THERAPY	19,190	5,103,307	0.003760			66.01
66.02	OP THERAPY SERVICES	50,204	14,058,880	0.003571			66.02
67	OCCUPATIONAL THERAPY	155,833	5,654,448	0.027559	1,929,816	53,184	67
68	SPEECH PATHOLOGY	12,455	2,137,252	0.005828	607,547	3,541	68
69	ELECTROCARDIOLOGY	252,361	23,423,038	0.010774	38,139	411	69
69.01	EP LAB	93,608	2,013,067	0.046500	30,136	1,401	69.01
69.02	VASCULAR SERVICES	7,952	3,638,710	0.002185			69.02
70	ELECTROENCEPHALOGRAPHY	28,962	1,371,365	0.021119	10,980	232	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,787	14,982,079	0.006126	255,413	1,565	71
72	IMPL. DEV. CHARGED TO PATIENTS	254,733	19,802,907	0.012863			72
73	DRUGS CHARGED TO PATIENTS	434,681	89,002,343	0.004884	1,188,640	5,805	73
74	RENAL DIALYSIS	17,725	5,323,151	0.003330	194,628	648	74
75	ASC (NON-DISTINCT PART)	473,876	4,352,145	0.108883			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	29,517	5,979,770	0.004936			76.01
76.97	CARDIAC REHABILITATION	20,110	3,017,731	0.006664			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	DIABETES CENTER						90.01
91	EMERGENCY	714,731	102,067,715	0.007003	4,483	31	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		12,168,399				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,148,117	782,510,492		7,678,097	102,599	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T172** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	BREAST DIAGNOSIS CENTER							54.01
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
65.01	SLEEP LAB							65.01
66	PHYSICAL THERAPY							66
66.01	OP PHYSICAL THERAPY							66.01
66.02	OP THERAPY SERVICES							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	WOUND CARE							76
76.01	OP ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T172** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	68,691,759			20,287				50
50.01	SURGICENTER	5,305,594							50.01
50.02	SURGERY RECOVERY CENTER	6,028,849							50.02
51	RECOVERY ROOM	10,846,387			26,458				51
53	ANESTHESIOLOGY	14,544,169			2,355				53
54	RADIOLOGY-DIAGNOSTIC	41,914,431			192,787				54
54.01	BREAST DIAGNOSIS CENTER	8,801,360							54.01
55	RADIOLOGY-THERAPEUTIC	13,747,865			16,101				55
56	RADIOISOTOPE	15,122,699			18,687				56
57	CT SCAN	84,667,846			116,808				57
58	MRI	22,187,421			23,029				58
59	CARDIAC CATHETERIZATION	50,118,073							59
60	LABORATORY	89,132,910			751,610				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	24,434,521			280,444				65
65.01	SLEEP LAB	3,030,337							65.01
66	PHYSICAL THERAPY	9,839,964			1,969,749				66
66.01	OP PHYSICAL THERAPY	5,103,307							66.01
66.02	OP THERAPY SERVICES	14,058,880							66.02
67	OCCUPATIONAL THERAPY	5,654,448			1,929,816				67
68	SPEECH PATHOLOGY	2,137,252			607,547				68
69	ELECTROCARDIOLOGY	23,423,038			38,139				69
69.01	EP LAB	2,013,067			30,136				69.01
69.02	VASCULAR SERVICES	3,638,710							69.02
70	ELECTROENCEPHALOGRAPHY	1,371,365			10,980				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,982,079			255,413				71
72	IMPL. DEV. CHARGED TO PATIENTS	19,802,907							72
73	DRUGS CHARGED TO PATIENTS	89,002,343			1,188,640				73
74	RENAL DIALYSIS	5,323,151			194,628				74
75	ASC (NON-DISTINCT PART)	4,352,145							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	5,979,770							76.01
76.97	CARDIAC REHABILITATION	3,017,731							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	102,067,715			4,483				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,168,399							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	782,510,492			7,678,097				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T172** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.283636							50
50.01	SURGICENTER	0.520213							50.01
50.02	SURGERY RECOVERY CENTER	0.392522							50.02
51	RECOVERY ROOM	0.212105							51
53	ANESTHESIOLOGY	0.063056							53
54	RADIOLOGY-DIAGNOSTIC	0.154493							54
54.01	BREAST DIAGNOSIS CENTER	0.238548							54.01
55	RADIOLOGY-THERAPEUTIC	0.233963							55
56	RADIOISOTOPE	0.135100							56
57	CT SCAN	0.034371							57
58	MRI	0.074614							58
59	CARDIAC CATHETERIZATION	0.115814							59
60	LABORATORY	0.169705							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.197144							65
65.01	SLEEP LAB	0.184568							65.01
66	PHYSICAL THERAPY	0.299191							66
66.01	OP PHYSICAL THERAPY	0.258889							66.01
66.02	OP THERAPY SERVICES	0.244037							66.02
67	OCCUPATIONAL THERAPY	0.335800							67
68	SPEECH PATHOLOGY	0.292677							68
69	ELECTROCARDIOLOGY	0.122998							69
69.01	EP LAB	0.496098							69.01
69.02	VASCULAR SERVICES	0.124871							69.02
70	ELECTROENCEPHALOGRAPHY	0.200122							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439							72
73	DRUGS CHARGED TO PATIENTS	0.274807							73
74	RENAL DIALYSIS	0.227308							74
75	ASC (NON-DISTINCT PART)	0.878629							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	0.209383							76.01
76.97	CARDIAC REHABILITATION	0.391115							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	0.167120							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	2,738,380		2,738,380	59,519	46.01	6,954	319,954	30
31	INTENSIVE CARE UNIT	589,372		589,372	7,487	78.72	539	42,430	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF	184,670		184,670	4,329	42.66	233	9,940	41
42	SUBPROVIDER I								42
43	NURSERY	97,896		97,896	2,899	33.77	2,602	87,870	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,610,318		3,610,318	74,234		10,328	460,194	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0172** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES:
[ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER)
[ ] TITLE XVIII, PART A [ ] IPF
[XX] TITLE XIX [ ] IRF

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,275,088	68,691,759	0.018562			50
50.01	SURGICENTER	42,700	5,305,594	0.008048			50.01
50.02	SURGERY RECOVERY CENTER	33,781	6,028,849	0.005603			50.02
51	RECOVERY ROOM	41,545	10,846,387	0.003830			51
53	ANESTHESIOLOGY	88,982	14,544,169	0.006118			53
54	RADIOLOGY-DIAGNOSTIC	564,642	41,914,431	0.013471			54
54.01	BREAST DIAGNOSIS CENTER	38,480	8,801,360	0.004372			54.01
55	RADIOLOGY-THERAPEUTIC	279,815	13,747,865	0.020353			55
56	RADIOISOTOPE	78,290	15,122,699	0.005177			56
57	CT SCAN	76,018	84,667,846	0.000898			57
58	MRI	30,117	22,187,421	0.001357			58
59	CARDIAC CATHETERIZATION	103,183	50,118,073	0.002059			59
60	LABORATORY	544,785	89,132,910	0.006112			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,173	24,434,521	0.005164			65
65.01	SLEEP LAB	36,460	3,030,337	0.012032			65.01
66	PHYSICAL THERAPY	130,333	9,839,964	0.013245			66
66.01	OP PHYSICAL THERAPY	19,190	5,103,307	0.003760			66.01
66.02	OP THERAPY SERVICES	50,204	14,058,880	0.003571			66.02
67	OCCUPATIONAL THERAPY	155,833	5,654,448	0.027559			67
68	SPEECH PATHOLOGY	12,455	2,137,252	0.005828			68
69	ELECTROCARDIOLOGY	252,361	23,423,038	0.010774			69
69.01	EP LAB	93,608	2,013,067	0.046500			69.01
69.02	VASCULAR SERVICES	7,952	3,638,710	0.002185			69.02
70	ELECTROENCEPHALOGRAPHY	28,962	1,371,365	0.021119			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,787	14,982,079	0.006126			71
72	IMPL. DEV. CHARGED TO PATIENTS	254,733	19,802,907	0.012863			72
73	DRUGS CHARGED TO PATIENTS	434,681	89,002,343	0.004884			73
74	RENAL DIALYSIS	17,725	5,323,151	0.003330			74
75	ASC (NON-DISTINCT PART)	473,876	4,352,145	0.108883			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	29,517	5,979,770	0.004936			76.01
76.97	CARDIAC REHABILITATION	20,110	3,017,731	0.006664			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	DIABETES CENTER						90.01
91	EMERGENCY	714,731	102,067,715	0.007003			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	330,569	12,168,399	0.027166			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,478,686	782,510,492				200

(A) Worksheet A line numbers

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	59,519		6,954		30
31	INTENSIVE CARE UNIT	7,487		539		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF	4,329		233		41
42	SUBPROVIDER I					42
43	NURSERY	2,899		2,602		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	74,234		10,328		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0172** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	BREAST DIAGNOSIS CENTER							54.01
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
65.01	SLEEP LAB							65.01
66	PHYSICAL THERAPY							66
66.01	OP PHYSICAL THERAPY							66.01
66.02	OP THERAPY SERVICES							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	WOUND CARE							76
76.01	OP ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0172** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	68,691,759							50
50.01	SURGICENTER	5,305,594							50.01
50.02	SURGERY RECOVERY CENTER	6,028,849							50.02
51	RECOVERY ROOM	10,846,387							51
53	ANESTHESIOLOGY	14,544,169							53
54	RADIOLOGY-DIAGNOSTIC	41,914,431							54
54.01	BREAST DIAGNOSIS CENTER	8,801,360							54.01
55	RADIOLOGY-THERAPEUTIC	13,747,865							55
56	RADIOISOTOPE	15,122,699							56
57	CT SCAN	84,667,846							57
58	MRI	22,187,421							58
59	CARDIAC CATHETERIZATION	50,118,073							59
60	LABORATORY	89,132,910							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	24,434,521							65
65.01	SLEEP LAB	3,030,337							65.01
66	PHYSICAL THERAPY	9,839,964							66
66.01	OP PHYSICAL THERAPY	5,103,307							66.01
66.02	OP THERAPY SERVICES	14,058,880							66.02
67	OCCUPATIONAL THERAPY	5,654,448							67
68	SPEECH PATHOLOGY	2,137,252							68
69	ELECTROCARDIOLOGY	23,423,038							69
69.01	EP LAB	2,013,067							69.01
69.02	VASCULAR SERVICES	3,638,710							69.02
70	ELECTROENCEPHALOGRAPHY	1,371,365							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,982,079							71
72	IMPL. DEV. CHARGED TO PATIENTS	19,802,907							72
73	DRUGS CHARGED TO PATIENTS	89,002,343							73
74	RENAL DIALYSIS	5,323,151							74
75	ASC (NON-DISTINCT PART)	4,352,145							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	5,979,770							76.01
76.97	CARDIAC REHABILITATION	3,017,731							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	102,067,715							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,168,399							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	782,510,492							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0172** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.283636							50
50.01	SURGICENTER	0.520213							50.01
50.02	SURGERY RECOVERY CENTER	0.392522							50.02
51	RECOVERY ROOM	0.212105							51
53	ANESTHESIOLOGY	0.063056							53
54	RADIOLOGY-DIAGNOSTIC	0.154493							54
54.01	BREAST DIAGNOSIS CENTER	0.238548							54.01
55	RADIOLOGY-THERAPEUTIC	0.233963							55
56	RADIOISOTOPE	0.135100							56
57	CT SCAN	0.034371							57
58	MRI	0.074614							58
59	CARDIAC CATHETERIZATION	0.115814							59
60	LABORATORY	0.169705							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.197144							65
65.01	SLEEP LAB	0.184568							65.01
66	PHYSICAL THERAPY	0.299191							66
66.01	OP PHYSICAL THERAPY	0.258889							66.01
66.02	OP THERAPY SERVICES	0.244037							66.02
67	OCCUPATIONAL THERAPY	0.335800							67
68	SPEECH PATHOLOGY	0.292677							68
69	ELECTROCARDIOLOGY	0.122998							69
69.01	EP LAB	0.496098							69.01
69.02	VASCULAR SERVICES	0.124871							69.02
70	ELECTROENCEPHALOGRAPHY	0.200122							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439							72
73	DRUGS CHARGED TO PATIENTS	0.274807							73
74	RENAL DIALYSIS	0.227308							74
75	ASC (NON-DISTINCT PART)	0.878629							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	0.209383							76.01
76.97	CARDIAC REHABILITATION	0.391115							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	0.167120							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T172** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER)

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,275,088	68,691,759	0.018562			50
50.01	SURGICENTER	42,700	5,305,594	0.008048			50.01
50.02	SURGERY RECOVERY CENTER	33,781	6,028,849	0.005603			50.02
51	RECOVERY ROOM	41,545	10,846,387	0.003830			51
53	ANESTHESIOLOGY	88,982	14,544,169	0.006118			53
54	RADIOLOGY-DIAGNOSTIC	564,642	41,914,431	0.013471			54
54.01	BREAST DIAGNOSIS CENTER	38,480	8,801,360	0.004372			54.01
55	RADIOLOGY-THERAPEUTIC	279,815	13,747,865	0.020353			55
56	RADIOISOTOPE	78,290	15,122,699	0.005177			56
57	CT SCAN	76,018	84,667,846	0.000898			57
58	MRI	30,117	22,187,421	0.001357			58
59	CARDIAC CATHETERIZATION	103,183	50,118,073	0.002059			59
60	LABORATORY	544,785	89,132,910	0.006112			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,173	24,434,521	0.005164			65
65.01	SLEEP LAB	36,460	3,030,337	0.012032			65.01
66	PHYSICAL THERAPY	130,333	9,839,964	0.013245			66
66.01	OP PHYSICAL THERAPY	19,190	5,103,307	0.003760			66.01
66.02	OP THERAPY SERVICES	50,204	14,058,880	0.003571			66.02
67	OCCUPATIONAL THERAPY	155,833	5,654,448	0.027559			67
68	SPEECH PATHOLOGY	12,455	2,137,252	0.005828			68
69	ELECTROCARDIOLOGY	252,361	23,423,038	0.010774			69
69.01	EP LAB	93,608	2,013,067	0.046500			69.01
69.02	VASCULAR SERVICES	7,952	3,638,710	0.002185			69.02
70	ELECTROENCEPHALOGRAPHY	28,962	1,371,365	0.021119			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,787	14,982,079	0.006126			71
72	IMPL. DEV. CHARGED TO PATIENTS	254,733	19,802,907	0.012863			72
73	DRUGS CHARGED TO PATIENTS	434,681	89,002,343	0.004884			73
74	RENAL DIALYSIS	17,725	5,323,151	0.003330			74
75	ASC (NON-DISTINCT PART)	473,876	4,352,145	0.108883			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	29,517	5,979,770	0.004936			76.01
76.97	CARDIAC REHABILITATION	20,110	3,017,731	0.006664			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	DIABETES CENTER						90.01
91	EMERGENCY	714,731	102,067,715	0.007003			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		12,168,399				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	6,148,117	782,510,492				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T172** **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	BREAST DIAGNOSIS CENTER							54.01
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
65.01	SLEEP LAB							65.01
66	PHYSICAL THERAPY							66
66.01	OP PHYSICAL THERAPY							66.01
66.02	OP THERAPY SERVICES							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	WOUND CARE							76
76.01	OP ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T172** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [ ] TITLE XVIII, PART A [XX] TITLE XIX | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	68,691,759							50
50.01	SURGICENTER	5,305,594							50.01
50.02	SURGERY RECOVERY CENTER	6,028,849							50.02
51	RECOVERY ROOM	10,846,387							51
53	ANESTHESIOLOGY	14,544,169							53
54	RADIOLOGY-DIAGNOSTIC	41,914,431							54
54.01	BREAST DIAGNOSIS CENTER	8,801,360							54.01
55	RADIOLOGY-THERAPEUTIC	13,747,865							55
56	RADIOISOTOPE	15,122,699							56
57	CT SCAN	84,667,846							57
58	MRI	22,187,421							58
59	CARDIAC CATHETERIZATION	50,118,073							59
60	LABORATORY	89,132,910							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	24,434,521							65
65.01	SLEEP LAB	3,030,337							65.01
66	PHYSICAL THERAPY	9,839,964							66
66.01	OP PHYSICAL THERAPY	5,103,307							66.01
66.02	OP THERAPY SERVICES	14,058,880							66.02
67	OCCUPATIONAL THERAPY	5,654,448							67
68	SPEECH PATHOLOGY	2,137,252							68
69	ELECTROCARDIOLOGY	23,423,038							69
69.01	EP LAB	2,013,067							69.01
69.02	VASCULAR SERVICES	3,638,710							69.02
70	ELECTROENCEPHALOGRAPHY	1,371,365							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,982,079							71
72	IMPL. DEV. CHARGED TO PATIENTS	19,802,907							72
73	DRUGS CHARGED TO PATIENTS	89,002,343							73
74	RENAL DIALYSIS	5,323,151							74
75	ASC (NON-DISTINCT PART)	4,352,145							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	5,979,770							76.01
76.97	CARDIAC REHABILITATION	3,017,731							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	102,067,715							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	12,168,399							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	782,510,492							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T172** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XIX - O/P | [ ] HOSPITAL [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.283636							50
50.01	SURGICENTER	0.520213							50.01
50.02	SURGERY RECOVERY CENTER	0.392522							50.02
51	RECOVERY ROOM	0.212105							51
53	ANESTHESIOLOGY	0.063056							53
54	RADIOLOGY-DIAGNOSTIC	0.154493							54
54.01	BREAST DIAGNOSIS CENTER	0.238548							54.01
55	RADIOLOGY-THERAPEUTIC	0.233963							55
56	RADIOISOTOPE	0.135100							56
57	CT SCAN	0.034371							57
58	MRI	0.074614							58
59	CARDIAC CATHETERIZATION	0.115814							59
60	LABORATORY	0.169705							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.197144							65
65.01	SLEEP LAB	0.184568							65.01
66	PHYSICAL THERAPY	0.299191							66
66.01	OP PHYSICAL THERAPY	0.258889							66.01
66.02	OP THERAPY SERVICES	0.244037							66.02
67	OCCUPATIONAL THERAPY	0.335800							67
68	SPEECH PATHOLOGY	0.292677							68
69	ELECTROCARDIOLOGY	0.122998							69
69.01	EP LAB	0.496098							69.01
69.02	VASCULAR SERVICES	0.124871							69.02
70	ELECTROENCEPHALOGRAPHY	0.200122							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439							72
73	DRUGS CHARGED TO PATIENTS	0.274807							73
74	RENAL DIALYSIS	0.227308							74
75	ASC (NON-DISTINCT PART)	0.878629							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	0.209383							76.01
76.97	CARDIAC REHABILITATION	0.391115							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	DIABETES CENTER								90.01
91	EMERGENCY	0.167120							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0172** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	59,519	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	59,519	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	52,334	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	28,776	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	49,697,419	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	49,697,419	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	49,697,419	37

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0172** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					834.98	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					24,027,384	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					24,027,384	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	13,413,641	7,487	1,791.59	4,270	7,650,089	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					35,738,643	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					67,416,116	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					1,660,118	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					1,312,448	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					2,972,566	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					64,443,550	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0172** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS
[XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA
[ ] TITLE XIX - I/P [ ] IRF [ ] NF [ ] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					7,185	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					834.98	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					5,999,331	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	2,738,380	49,697,419	0.055101	5,999,331	330,569	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T172** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**	
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] TITLE XIX - I/P	**[XX] IRF**	**[ ] NF**		**[ ] OTHER**	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,329	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,329	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,329	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	3,278	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	3,646,858	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,646,858	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	3,646,858	37

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T172** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	842.43	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	2,761,486	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	2,761,486	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	2,111,230	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	4,872,716	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	139,839	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	102,599	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	242,438	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	4,630,278	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0172** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] PPS**	
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] OTHER**	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	59,519	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	59,519	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	52,334	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	6,954	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	2,899	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	2,602	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	49,669,018	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	49,669,018	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	49,669,018	37

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0172** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					834.51	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					5,803,183	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					5,803,183	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)	2,050,565	2,899	707.34	2,602	1,840,499	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	13,402,945	7,487	1,790.16	539	964,896	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					8,608,578	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					450,254	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					450,254	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0172** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [ ] NF [XX] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					7,185	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T172** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XIX - I/P | [ ] HOSPITAL [ ] IPF [XX] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,329	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	4,329	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,329	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	233	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	3,637,640	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,637,640	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	3,637,640	37

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T172** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [ ] HOSPITAL [ ] SUB (OTHER) [ ] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [XX] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	840.30	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	195,790	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	195,790	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	195,790	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	9,940	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	9,940	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0172** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[ ] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] OTHER**

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		45,870,683		30
31	INTENSIVE CARE UNIT		12,639,624		31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.303019	13,648,103	4,135,635	50
50.01	SURGICENTER	0.584906			50.01
50.02	SURGERY RECOVERY CENTER	0.392522			50.02
51	RECOVERY ROOM	0.212105	1,763,493	374,046	51
53	ANESTHESIOLOGY	0.063056	2,838,637	178,993	53
54	RADIOLOGY-DIAGNOSTIC	0.154493	8,629,145	1,333,142	54
54.01	BREAST DIAGNOSIS CENTER	0.238719	14,633	3,493	54.01
55	RADIOLOGY-THERAPEUTIC	0.233963	354,062	82,837	55
56	RADIOISOTOPE	0.135100	2,225,967	300,728	56
57	CT SCAN	0.034371	16,089,360	553,007	57
58	MRI	0.074614	3,122,665	232,995	58
59	CARDIAC CATHETERIZATION	0.115814	17,033,745	1,972,746	59
60	LABORATORY	0.169964	27,388,038	4,654,980	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.197246	12,333,017	2,432,638	65
65.01	SLEEP LAB	0.185591	9,836	1,825	65.01
66	PHYSICAL THERAPY	0.299191	2,164,517	647,604	66
66.01	OP PHYSICAL THERAPY	0.258889			66.01
66.02	OP THERAPY SERVICES	0.244037			66.02
67	OCCUPATIONAL THERAPY	0.335800	1,471,204	494,030	67
68	SPEECH PATHOLOGY	0.292677	747,614	218,809	68
69	ELECTROCARDIOLOGY	0.124250	6,603,665	820,505	69
69.01	EP LAB	0.496098	657,305	326,088	69.01
69.02	VASCULAR SERVICES	0.124871	1,035,988	129,365	69.02
70	ELECTROENCEPHALOGRAPHY	0.200122	254,495	50,930	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334	5,114,703	1,316,187	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439	7,742,613	3,990,845	72
73	DRUGS CHARGED TO PATIENTS	0.274807	27,066,512	7,438,067	73
74	RENAL DIALYSIS	0.227308	3,439,537	781,834	74
75	ASC (NON-DISTINCT PART)	0.878629	198,600	174,496	75
76	WOUND CARE				76
76.01	OP ONCOLOGY	0.209383			76.01
76.97	CARDIAC REHABILITATION	0.391619			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	DIABETES CENTER				90.01
91	EMERGENCY	0.172407	13,834,511	2,385,167	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025	1,435,325	707,651	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		177,217,290	35,738,643	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		177,217,290		202

(A) Worksheet A line numbers

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T172** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[XX] PPS**
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[ ] TITLE XIX	**[XX] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] OTHER**

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF		5,408,026		41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.303019	20,287	6,147	50
50.01	SURGICENTER	0.584906			50.01
50.02	SURGERY RECOVERY CENTER	0.392522			50.02
51	RECOVERY ROOM	0.212105	26,458	5,612	51
53	ANESTHESIOLOGY	0.063056	2,355	148	53
54	RADIOLOGY-DIAGNOSTIC	0.154493	192,787	29,784	54
54.01	BREAST DIAGNOSIS CENTER	0.238719			54.01
55	RADIOLOGY-THERAPEUTIC	0.233963	16,101	3,767	55
56	RADIOISOTOPE	0.135100	18,687	2,525	56
57	CT SCAN	0.034371	116,808	4,015	57
58	MRI	0.074614	23,029	1,718	58
59	CARDIAC CATHETERIZATION	0.115814			59
60	LABORATORY	0.169964	751,610	127,747	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.197246	280,444	55,316	65
65.01	SLEEP LAB	0.185591			65.01
66	PHYSICAL THERAPY	0.299191	1,969,749	589,331	66
66.01	OP PHYSICAL THERAPY	0.258889			66.01
66.02	OP THERAPY SERVICES	0.244037			66.02
67	OCCUPATIONAL THERAPY	0.335800	1,929,816	648,032	67
68	SPEECH PATHOLOGY	0.292677	607,547	177,815	68
69	ELECTROCARDIOLOGY	0.124250	38,139	4,739	69
69.01	EP LAB	0.496098	30,136	14,950	69.01
69.02	VASCULAR SERVICES	0.124871			69.02
70	ELECTROENCEPHALOGRAPHY	0.200122	10,980	2,197	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334	255,413	65,726	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439			72
73	DRUGS CHARGED TO PATIENTS	0.274807	1,188,640	326,647	73
74	RENAL DIALYSIS	0.227308	194,628	44,241	74
75	ASC (NON-DISTINCT PART)	0.878629			75
76	WOUND CARE				76
76.01	OP ONCOLOGY	0.209383			76.01
76.97	CARDIAC REHABILITATION	0.391619			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	DIABETES CENTER				90.01
91	EMERGENCY	0.172407	4,483	773	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		7,678,097	2,111,230	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		7,678,097		202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0172** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[ ] PPS**
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[XX] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] OTHER**

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.283636			50
50.01	SURGICENTER	0.520213			50.01
50.02	SURGERY RECOVERY CENTER	0.392522			50.02
51	RECOVERY ROOM	0.212105			51
53	ANESTHESIOLOGY	0.063056			53
54	RADIOLOGY-DIAGNOSTIC	0.154493			54
54.01	BREAST DIAGNOSIS CENTER	0.238548			54.01
55	RADIOLOGY-THERAPEUTIC	0.233963			55
56	RADIOISOTOPE	0.135100			56
57	CT SCAN	0.034371			57
58	MRI	0.074614			58
59	CARDIAC CATHETERIZATION	0.115814			59
60	LABORATORY	0.169705			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.197144			65
65.01	SLEEP LAB	0.184568			65.01
66	PHYSICAL THERAPY	0.299191			66
66.01	OP PHYSICAL THERAPY	0.258889			66.01
66.02	OP THERAPY SERVICES	0.244037			66.02
67	OCCUPATIONAL THERAPY	0.335800			67
68	SPEECH PATHOLOGY	0.292677			68
69	ELECTROCARDIOLOGY	0.122998			69
69.01	EP LAB	0.496098			69.01
69.02	VASCULAR SERVICES	0.124871			69.02
70	ELECTROENCEPHALOGRAPHY	0.200122			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439			72
73	DRUGS CHARGED TO PATIENTS	0.274807			73
74	RENAL DIALYSIS	0.227308			74
75	ASC (NON-DISTINCT PART)	0.878629			75
76	WOUND CARE				76
76.01	OP ONCOLOGY	0.209383			76.01
76.97	CARDIAC REHABILITATION	0.391115			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	DIABETES CENTER				90.01
91	EMERGENCY	0.167120			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T172** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[ ] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[ ] PPS**
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[XX] TITLE XIX	**[XX] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] OTHER**

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
41	SUBPROVIDER - IRF				41
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.283636			50
50.01	SURGICENTER	0.520213			50.01
50.02	SURGERY RECOVERY CENTER	0.392522			50.02
51	RECOVERY ROOM	0.212105			51
53	ANESTHESIOLOGY	0.063056			53
54	RADIOLOGY-DIAGNOSTIC	0.154493			54
54.01	BREAST DIAGNOSIS CENTER	0.238548			54.01
55	RADIOLOGY-THERAPEUTIC	0.233963			55
56	RADIOISOTOPE	0.135100			56
57	CT SCAN	0.034371			57
58	MRI	0.074614			58
59	CARDIAC CATHETERIZATION	0.115814			59
60	LABORATORY	0.169705			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.197144			65
65.01	SLEEP LAB	0.184568			65.01
66	PHYSICAL THERAPY	0.299191			66
66.01	OP PHYSICAL THERAPY	0.258889			66.01
66.02	OP THERAPY SERVICES	0.244037			66.02
67	OCCUPATIONAL THERAPY	0.335800			67
68	SPEECH PATHOLOGY	0.292677			68
69	ELECTROCARDIOLOGY	0.122998			69
69.01	EP LAB	0.496098			69.01
69.02	VASCULAR SERVICES	0.124871			69.02
70	ELECTROENCEPHALOGRAPHY	0.200122			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257334			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.515439			72
73	DRUGS CHARGED TO PATIENTS	0.274807			73
74	RENAL DIALYSIS	0.227308			74
75	ASC (NON-DISTINCT PART)	0.878629			75
76	WOUND CARE				76
76.01	OP ONCOLOGY	0.209383			76.01
76.97	CARDIAC REHABILITATION	0.391115			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	DIABETES CENTER				90.01
91	EMERGENCY	0.167120			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.493025			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	42,017,264			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	12,105,885			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	1,194,458			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	4,887,961			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	291.48			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)	124.92			5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)	9.24			7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002	-24.61			8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)	91.07			9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	85.86			10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	85.86			12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	80.83			13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	78.63			14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	81.77			15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	81.77			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.280534			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.247527			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.247527			21
22	IME PAYMENT ADJUSTMENT (see instructions)	7,465,023			22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)	-5.21			24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)	7,465,023			29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0477			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2218			31
32	SUM OF LINES 30 AND 31	0.2695			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1145			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	5,157,508			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		

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CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		5,558,733		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		1,401,106		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	1,401,106			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	69,341,244			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	69,341,244			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	5,234,460			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)	3,706,559			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	78,282,263			59
60	PRIMARY PAYER PAYMENTS	36,170			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	78,246,093			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	5,394,292			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	586,730			63
64	ALLOWABLE BAD DEBTS (see instructions)	2,688,619			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	1,747,602			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	2,018,767			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	74,012,673			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	60,037			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-538,812			70.94
71	AMOUNT DUE PROVIDER (see instructions)	73,533,898			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,110,362			71.01
72	INTERIM PAYMENTS	70,117,353			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	2,306,183			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	620,787			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0172** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	11,383			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	22,314,667			2
3	PPS PAYMENTS	21,789,094			3
4	OUTLIER PAYMENT (see instructions)	72,571			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	11,383			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	45,083			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	45,083			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT 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)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	45,083			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	33,700			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	11,383			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	21,861,665			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	1,276			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	4,774,085			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	17,097,687			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	1,145,091			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	18,242,778			30
31	PRIMARY PAYER PAYMENTS	4,694			31
32	SUBTOTAL (line 30 minus line 31)	18,238,084			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	1,167,094			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	758,611			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	880,690			36
37	SUBTOTAL (see instructions)	18,996,695			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	18,996,695			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	286,850			40.01
41	INTERIM PAYMENTS	18,440,366			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	269,479			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T172** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [XX] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.850			5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT 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)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0172** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				70,576,589		18,431,028	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01			12/23/2013	94,838	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	07/24/2013	99,338	07/24/2013	85,500	3.51
		PROVIDER	.52	12/23/2013	359,898			3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-459,236		9,338	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				70,117,353		18,440,366	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		3,416,545		556,329	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				73,533,898		18,996,695	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-T172** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] SUB (OTHER)** **[ ] IPF [ ] SNF** **[XX] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				4,425,126			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	07/24/2013	95,098			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		95,098			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				4,520,224			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02		-57,276			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				4,462,948			7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	15,989	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	33,046	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,976	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	59,821	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	919,078,905	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	40,351,649	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	3,128,846	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	62,577	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	3,066,269	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	3,453,576	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-387,307	32

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T172** **WORKSHEET E-3 PART III**

CHECK APPLICABLE BOX: **[ ] HOSPITAL** **[XX] SUBPROVIDER IRF**

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	3,026,238	1,008,746	1
2	MEDICARE SSI RATIO (see instructions)	0.040600		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	156,154	35,609	3
4	OUTLIER PAYMENTS	35,724		4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)	1.30		5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSUE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)	0.98		7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)	0.98		9
10	AVERAGE DAILY CENSUS (see instructions)	11.860274		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)	0.056108	0.084031	11
12	TEACHING ADJUSTMENT (see instructions)	169,796	84,766	12
13	TOTAL PPS PAYMENT (see instructions)	4,517,033		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	4,517,033		17
18	PRIMARY PAYER PAYMENTS	615		18
19	SUBTOTAL (line 17 less line 18)	4,516,418		19
20	DEDUCTIBLES	26,048		20
21	SUBTOTAL (line 19 minus line 20)	4,490,370		21
22	COINSURANCE	31,045		22
23	SUBTOTAL (line 21 minus line 22)	4,459,325		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	5,574		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	3,623		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	4,606		26
27	SUBTOTAL (sum of lines 23 and 25)	4,462,948		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	4,462,948		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	67,391		32.01
33	INTERIM PAYMENTS	4,520,224		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	-124,667		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)			50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)			52
53	TIME VALUE OF MONEY (see instructions)			53

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0172** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[ ] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] OTHER**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	8,608,578		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	8,608,578		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	8,608,578		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	2,459,906		8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	2,459,906		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT 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)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	2,459,906		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	6,148,672		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)	2,459,906		21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	2,459,906		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	2,459,906		31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	2,459,906		36
37	OTHER ADJUSTMENTS (REMOVE IP COSTS)			37
38	SUBTOTAL (line 36 ± line 37)	2,459,906		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	2,459,906		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	2,459,906		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T172** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XIX** **[ ] PPS** **[ ] TEFRA** **[XX] OTHER**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	195,790		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	195,790		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	195,790		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT 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)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	195,790		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			128.25	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			10.23	3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))			-24.64	4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			93.38	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)			86.83	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			86.83	7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	26.29	52.71	79.00	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	26.29	52.71	79.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	26.29	52.71		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	17.61	58.02		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	12.92	62.22		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	18.94	57.65		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	18.94	57.65		17
18	PER RESIDENT AMOUNT	106,384.64	103,483.77		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	2,014,925	5,965,839	7,980,764	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)			7,980,764	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	36,324	3,114		26
27	TOTAL INPATIENT DAYS (see instructions)	64,150	64,150		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.566235	0.048542		28
29	PROGRAM DIRECT GME AMOUNT	4,518,988	387,402		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		54,740		30
31	NET PROGRAM DIRECT GME AMOUNT			4,851,650	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)			5,323,151	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)			72,288,832	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)			36,785	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			72,252,047	41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)			22,326,050	42
43	PRIMARY PAYER PAYMENTS (see instructions)			4,694	43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			22,321,356	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			94,573,403	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.763979	46

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)	0.236021	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (line 31)	4,851,650	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)	3,706,559	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)	1,145,091	50

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX:
[ ] TITLE V
[ ] TITLE XVIII
[XX] TITLE XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	ADJUSTMENT (plus or minus) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (see instructions for cost reporting periods straddling 7/1/2011				4.02
5	FTE ADJUSTED CAP (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (see instructions)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE	OTHER	TOTAL	
		1	2	3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.00	0.00	0.00	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.00	0.00	0.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		0.00		10
11	TOTAL WEIGHTED FTE COUNT	0.00	0.00		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	0.00		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	0.00		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	0.00		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	0.00		17
18	PER RESIDENT AMOUNT	0.00	0.00		18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (see instructions)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (see instructions)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (see instructions)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	7,726	3,731		26
27	TOTAL INPATIENT DAYS (see instructions)	64,150	64,150		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.120436	0.058161		28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 8, sum of lines 74 and 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (line 32 ÷ line 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (see instructions)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (see instructions)				37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)				40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (see instructions)				42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)				44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)				46

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

CHECK APPLICABLE BOX:
[ ] TITLE V
[ ] TITLE XVIII
[XX] TITLE XIX

47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)		47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	TOTAL PROGRAM GME PAYMENT (line 31)		48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)		49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)		50

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	12,378,772				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	71,496,945				4
5	OTHER RECEIVABLES	21,609,065				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-25,431,156				6
7	INVENTORY	7,060,240				7
8	PREPAID EXPENSES	1,804,328				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	88,918,194				11
	FIXED ASSETS					
12	LAND	7,320,500				12
13	LAND IMPROVEMENTS	3,934,713				13
14	ACCUMULATED DEPRECIATION	-3,038,928				14
15	BUILDINGS	114,298,541				15
16	ACCUMULATED DEPRECIATION	-71,581,192				16
17	LEASEHOLD IMPROVEMENTS	1,075,647				17
18	ACCUMULATED AMORTIZATION	-102,538				18
19	FIXED EQUIPMENT	90,239,597				19
20	ACCUMULATED DEPRECIATION	-42,079,738				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	78,592,539				23
24	ACCUMULATED DEPRECIATION	-44,683,800				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	133,975,341				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	14,870,006				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	14,870,006				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	237,763,541				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	15,546,897				37
38	SALARIES, WAGES & FEES PAYABLE	7,106,647				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	465,351				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	8,742,661				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	31,861,556				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	822,880				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	-5,302,495				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	-4,479,615				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	27,381,941				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	210,381,600				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	210,381,600				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	237,763,541				60

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STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		164,967,158		40,000	1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-8,071,126			2
3	TOTAL (sun of line 1 and line 2)		156,896,032		40,000	3
4	ADDITIONS (credit adjustments)					4
5	TRANSFERS FROM AFFILIATES	53,226,161				5
6	NET ASSETS RELEASED FROM RESTR ASSE	259,407				6
7	OTHER					7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		53,485,568			10
11	SUBTOTAL (line 3 plus line 10)		210,381,600		40,000	11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED FROM RESTRTED			40,000		13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)				40,000	18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		210,381,600			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	TRANSFERS FROM AFFILIATES					5
6	NET ASSETS RELEASED FROM RESTR ASSE					6
7	OTHER					7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	NET ASSETS RELEASED FROM RESTRTED					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	91,886,893		91,886,893	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF	7,002,378		7,002,378	3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	98,889,271		98,889,271	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	22,147,845		22,147,845	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	22,147,845		22,147,845	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	121,037,116		121,037,116	17
18	ANCILLARY SERVICES	351,294,912	440,770,935	792,065,847	18
19	OUTPATIENT SERVICES		10,054,375	10,054,375	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		6,027,412	6,027,412	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	PHYSICIANS REVENUE	6,823,096	6,938,232	13,761,328	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	479,155,124	463,790,954	942,946,078	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		294,665,342	29
30	BAD DEBTS	15,406,715		30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		15,406,715	36
37	DEDUCT (SPECIFY)			37
38	GAIN ON DISPOSAL OF ASSETS	-251,890		38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)		-251,890	42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		309,820,167	43

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	942,946,078	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	660,757,241	2
3	NET PATIENT REVENUES (line 1 minus line 2)	282,188,837	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	309,820,167	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-27,631,330	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	5,079	6
7	INCOME FROM INVESTMENTS	1,291,963	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES	85,633	8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES	1,298,341	11
12	PARKING LOT RECEIPTS	79,572	12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	1,110,996	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	30,410	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	336,014	20
21	RENTAL OF VENDING MACHINES	27,327	21
22	RENTAL OF HOSPITAL SPACE	2,154,341	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.01	OTHER (EMERGENCY MEDICAL TECHNICIAN REVENU)	6,550	24.01
24.02	OTHER (BILLING SERVICES)	43,010	24.02
24.03	OTHER (DIABETES CENTER)	2,572	24.03
24.05	OTHER (RADIOLOGY REVENUE)	3,239	24.05
24.06	OTHER (HOSPICE REVENUE)	251,437	24.06
24.07	OTHER (OB/NURSERY OTHER REVENUES)	2,875	24.07
24.08	OTHER (OTHER NON OPERATING REVENUE)		24.08
24.09	OTHER (DIETARY SPECIAL FUNCTIONS)	14,616	24.09
24.10	OTHER (RETAIL PHARMACY)	1,124,679	24.10
24.11	OTHER (FITNESS CENTER)	2,742,570	24.11
24.12	OTHER (THIRD PARTY AUDIT FEES)		24.12
24.13	OTHER (EKG OTHER REVENUE)	9,180	24.13
24.14	OTHER (SENIOR SERVICES)	12,166	24.14
24.15	OTHER (OTHER NON-OPERATING EXPENSES)	3,919,331	24.15
24.16	OTHER (UNREALIZED GAIN ON INVESTMENTS)	12,254	24.16
24.17	OTHER (MEANINGFUL USE REVENUE)	4,749,876	24.17
24.18	OTHER (ASSETS RELEASED FROM REST OR OPERAT)		24.18
24.19	OTHER (OTHER MISCELLANEOUS REVENUE, NET)	246,173	24.19
25	TOTAL OTHER INCOME (sum of lines 6-24)	19,560,204	25
26	TOTAL (line 5 plus line 25)	-8,071,126	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-8,071,126	29

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7267** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	715,188	200,253	2,495		111,383	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	1,483,929	415,500	72,120			6
7	PHYSICAL THERAPY	64,948	18,185		662,384		7
8	OCCUPATIONAL THERAPY	20,761	5,813		210,716		8
9	SPEECH PATHOLOGY	15,327	4,292	232	24,401		9
10	MEDICAL SOCIAL SERVICES				19,500		10
11	HOME HEALTH AIDE	241,373	67,584	19,716			11
12	SUPPLIES (see instructions)					135,824	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	2,541,526	711,627	94,563	917,001	247,207	24

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7267** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	1,029,319	-487,606	541,713		541,713	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	1,971,549		1,971,549		1,971,549	6
7	PHYSICAL THERAPY	745,517		745,517		745,517	7
8	OCCUPATIONAL THERAPY	237,290		237,290		237,290	8
9	SPEECH PATHOLOGY	44,252		44,252		44,252	9
10	MEDICAL SOCIAL SERVICES	19,500		19,500		19,500	10
11	HOME HEALTH AIDE	328,673		328,673		328,673	11
12	SUPPLIES (see instructions)	135,824		135,824		135,824	12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	4,511,924	-487,606	4,024,318		4,024,318	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7267** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	541,713				5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE	1,971,549				6
7	PHYSICAL THERAPY	745,517				7
8	OCCUPATIONAL THERAPY	237,290				8
9	SPEECH PATHOLOGY	44,252				9
10	MEDICAL SOCIAL SERVICES	19,500				10
11	HOME HEALTH AIDE	328,673				11
12	SUPPLIES (see instructions)	135,824				12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	4,024,318				24

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7267** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		541,713	541,713		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		1,971,549	306,672	2,278,221	6
7	PHYSICAL THERAPY		745,517	115,964	861,481	7
8	OCCUPATIONAL THERAPY		237,290	36,910	274,200	8
9	SPEECH PATHOLOGY		44,252	6,883	51,135	9
10	MEDICAL SOCIAL SERVICES		19,500	3,033	22,533	10
11	HOME HEALTH AIDE		328,673	51,124	379,797	11
12	SUPPLIES (see instructions)		135,824	21,127	156,951	12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		4,024,318		4,024,318	24

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7267** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-541,713	3,482,605	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						1,971,549	6
7	PHYSICAL THERAPY						745,517	7
8	OCCUPATIONAL THERAPY						237,290	8
9	SPEECH PATHOLOGY						44,252	9
10	MEDICAL SOCIAL SERVICES						19,500	10
11	HOME HEALTH AIDE						328,673	11
12	SUPPLIES (see instructions)						135,824	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					-541,713	3,482,605	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						541,713	25
26	UNIT COST MULTIPLIER						0.155548	26

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7267** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL				3,616	3,616	1,048	1
2	SKILLED NURSING CARE	2,278,221			15,075	2,293,296	664,637	2
3	PHYSICAL THERAPY	861,481			660	862,141	249,863	3
4	OCCUPATIONAL THERAPY	274,200			211	274,411	79,529	4
5	SPEECH PATHOLOGY	51,135			156	51,291	14,865	5
6	MEDICAL SOCIAL SERVICES	22,533				22,533	6,530	6
7	HOME HEALTH AIDE	379,797			2,452	382,249	110,782	7
8	SUPPLIES	156,951				156,951	45,487	8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	4,024,318			22,170	4,046,488	1,172,741	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7267** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL						15,022	1
2	SKILLED NURSING CARE						48,130	2
3	PHYSICAL THERAPY						1,881	3
4	OCCUPATIONAL THERAPY						592	4
5	SPEECH PATHOLOGY						283	5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE						13,475	7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)						79,383	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7267** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES * SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL				401			1
2	SKILLED NURSING CARE					14,586		2
3	PHYSICAL THERAPY					7,181		3
4	OCCUPATIONAL THERAPY					2,241		4
5	SPEECH PATHOLOGY					296		5
6	MEDICAL SOCIAL SERVICES					194		6
7	HOME HEALTH AIDE					2,228		7
8	SUPPLIES			14,572		1,211		8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)			14,572	401	27,937		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7267** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	RADIOLOGY PARAMEDICA	
		19	20	21	22	23	23.01	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7267** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (sum of col.4A-23)	ALLOCATED HHA A&G (see Pt.2)	TOTAL HHA COSTS		
		24	25	26	27	28		
1	ADMINISTRATIVE AND GENERAL	20,087		20,087				1
2	SKILLED NURSING CARE	3,020,649		3,020,649	11,402	3,032,051		2
3	PHYSICAL THERAPY	1,121,066		1,121,066	4,232	1,125,298		3
4	OCCUPATIONAL THERAPY	356,773		356,773	1,347	358,120		4
5	SPEECH PATHOLOGY	66,735		66,735	252	66,987		5
6	MEDICAL SOCIAL SERVICES	29,257		29,257	110	29,367		6
7	HOME HEALTH AIDE	508,734		508,734	1,920	510,654		7
8	SUPPLIES	218,221		218,221	824	219,045		8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	5,341,522		5,341,522	20,087	5,341,522		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.003775			21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7267 **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL			355,943		3,616		1
2	SKILLED NURSING CARE			1,483,929		2,293,296		2
3	PHYSICAL THERAPY			64,948		862,141		3
4	OCCUPATIONAL THERAPY			20,761		274,411		4
5	SPEECH PATHOLOGY			15,327		51,291		5
6	MEDICAL SOCIAL SERVICES					22,533		6
7	HOME HEALTH AIDE			241,373		382,249		7
8	SUPPLIES					156,951		8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)			2,182,281		4,046,488		20
21	TOTAL COST TO BE ALLOCATED			22,170		1,172,741		21
22	UNIT COST MULTIPLIER			0.010159		0.289817		22
22	UNIT COST MULTIPLIER							22

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7267 **WORKSHEET H-2 PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA PROD FTE'S	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL					11,343		1
2	SKILLED NURSING CARE					36,343		2
3	PHYSICAL THERAPY					1,420		3
4	OCCUPATIONAL THERAPY					447		4
5	SPEECH PATHOLOGY					214		5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE					10,175		7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)					59,942		20
21	TOTAL COST TO BE ALLOCATED					79,383		21
22	UNIT COST MULTIPLIER					1.324330		22
22	UNIT COST MULTIPLIER							22

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7267 **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING ADMINIS-TRATION NURS DIRECT FTE	CENTRAL SERVICES * SUPPLY COSTED REQUI	PHARMACY COSTED REQUI	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL			1,430				1
2	SKILLED NURSING CARE				3,146,850			2
3	PHYSICAL THERAPY				1,549,260			3
4	OCCUPATIONAL THERAPY				483,590			4
5	SPEECH PATHOLOGY				63,825			5
6	MEDICAL SOCIAL SERVICES				41,830			6
7	HOME HEALTH AIDE				480,795			7
8	SUPPLIES		135,924		261,263			8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)		135,924	1,430	6,027,413			20
21	TOTAL COST TO BE ALLOCATED		14,572	401	27,937			21
22	UNIT COST MULTIPLIER			0.280420				22
22	UNIT COST MULTIPLIER		0.107207		0.004635			22

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS HHA CCN: 14-7267 **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	RADIOLOGY PARAMEDICA TIME SPENT		
		20	21	22	23	23.01		
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7267** **WORKSHEET H-3 PARTS I & II**

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION								
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PEr VISIT (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	3,032,051		3,032,051	17,216	176.12	1
2	PHYSICAL THERAPY	3	1,125,298		1,125,298	8,259	136.25	2
3	OCCUPATIONAL THERAPY	4	358,120		358,120	2,640	135.65	3
4	SPEECH PATHOLOGY	5	66,987		66,987	347	193.05	4
5	MEDICAL SOCIAL SERVICES	6	29,367		29,367	178	164.98	5
6	HOME HEALTH AIDE	7	510,654		510,654	4,586	111.35	6
7	TOTAL (sum of lines 1-6)		5,122,477		5,122,477	33,226		7

LIMITATION COST COMPUTATION			PROGRAM VISITS			
				PART B		
	PATIENT SERVICES	CBSA NO.	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
		1	2	3	4	
8	SKILLED NURSING CARE	16974	6,579	5,432		8
9	PHYSICAL THERAPY	16974	3,281	2,553		9
10	OCCUPATIONAL THERAPY	16974	1,095	763		10
11	SPEECH PATHOLOGY	16974	145	54		11
12	MEDICAL SOCIAL SERVICES	16974	61	77		12
13	HOME HEALTH AIDE	16974	1,829	2,307		13
14	TOTAL (sum of lines 8-13)		12,990	11,186		14

SUPPLIES AND DRUGS COSTS COMPUTATIONS								
	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	219,045		219,045	240,422	0.911086	15
16	COST OF DRUGS	9						16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED	
			1	2	3	4	
1	PHYSICAL THERAPY	66	0.299191			col. 2, line 2	1
1.01	OP PHYSICAL THERAPY	66.01	0.258889			col. 2, line 2	1.01
1.02	OP THERAPY SERVICES	66.02	0.244037			col. 2, line 2	1.02
2	OCCUPATIONAL THERAPY	67	0.335800			col. 2, line 3	2
3	SPEECH PATHOLOGY	68	0.292677			col. 2, line 4	3
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.257334			col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.274807			col. 2, line 16	5

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7267** **WORKSHEET H-3 PARTS I & II**

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS			COST OF SERVICES				
			PART B			PART B			
	PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL PROGRAM COST (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	6,579	5,432		1,158,693	956,684		2,115,377	1
2	PHYSICAL THERAPY	3,281	2,553		447,036	347,846		794,882	2
3	OCCUPATIONAL THERAPY	1,095	763		148,537	103,501		252,038	3
4	SPEECH PATHOLOGY	145	54		27,992	10,425		38,417	4
5	MEDICAL SOCIAL SERVICES	61	77		10,064	12,703		22,767	5
6	HOME HEALTH AIDE	1,829	2,307		203,659	256,884		460,543	6
7	TOTAL (sum of lines 1-6)	12,990	11,186		1,995,981	1,688,043		3,684,024	7

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES			
			PART B			PART B		
	OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS-URANCE	SUBJECT TO DEDUCTIBLES & COINS-URANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINS-URANCE	SUBJECT TO DEDUCTIBLES & COINS-URANCE	
		6	7	8	9	10	11	
15	COST OF MEDICAL SUPPLIES							15
16	COST OF DRUGS							16

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7267** **WORKSHEET H-4**
PARTS I & II

CHECK APPLICABLE BOX: [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

			PART B		
		PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
	DESCRIPTION	1	2	3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES	3,063,807			2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE I ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to excced 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)	3,063,807			6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)	3,063,807			7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS				9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		PART A SERVICES	PART B SERVICES	
	DESCRIPTION	1	2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	2,735,023	1,486,472	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	25,851	9,031	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	35,446	18,469	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	20,616	6,343	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	2,816,936	1,520,315	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	2,816,936	1,520,315	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	2,816,936	1,520,315	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	2,816,936	1,520,315	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	2,816,936	1,520,315	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)			31.01
32	INTERIM PAYMENTS (see instructions)	2,816,936	1,520,315	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7267** **WORKSHEET H-5**

				PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,816,936		1,520,315	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				2,816,936		1,520,315	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				2,816,936		1,520,315	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0172** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	4,308,803	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	32,442	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	163.89	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	81.77	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	15.12	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	651,491	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0477	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.2218	8
9	SUM OF LINES 7 AND 8	0.2695	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0561	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	241,724	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	5,234,460	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
41	SUBPROVIDER - IRF							41
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	BREAST DIAGNOSIS CENTER							54.01
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
65.01	SLEEP LAB							65.01
66	PHYSICAL THERAPY							66
66.01	OP PHYSICAL THERAPY							66.01
66.02	OP THERAPY SERVICES							66.02
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	WOUND CARE							76
76.01	OP ONCOLOGY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	DIABETES CENTER							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
101	HOME HEALTH AGENCY							101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
191	RESEARCH							191
192	PHYSICIANS' PRIVATE OFFICES							192
193	NONPAID WORKERS							193
194	DEVELOPMENT							194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	48.35		11.68				60.03	30
31	INTENSIVE CARE UNIT	57.03		7.20				64.23	31
43	NURSERY			89.76				89.76	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	19.87	17.32					37.19	50
50.01	SURGICENTER		28.70					28.70	50.01
51	RECOVERY ROOM	16.26	20.28					36.54	51
53	ANESTHESIOLOGY	19.52	15.77					35.29	53
54	RADIOLOGY-DIAGNOSTIC	20.59	11.09					31.68	54
54.01	BREAST DIAGNOSIS CENTER	0.17	12.53					12.70	54.01
55	RADIOLOGY-THERAPEUTIC	2.58	42.78					45.36	55
56	RADIOISOTOPE	14.72	32.70					47.42	56
57	CT SCAN	19.00	16.52					35.52	57
58	MRI	14.07	20.26					34.33	58
59	CARDIAC CATHETERIZATION	33.99	22.37					56.36	59
60	LABORATORY	30.73	2.14					32.87	60
65	RESPIRATORY THERAPY	50.47	2.84					53.31	65
65.01	SLEEP LAB	0.32	26.12					26.44	65.01
66	PHYSICAL THERAPY	22.00	0.04					22.04	66
66.02	OP THERAPY SERVICES		0.01					0.01	66.02
67	OCCUPATIONAL THERAPY	26.02	0.02					26.04	67
68	SPEECH PATHOLOGY	34.98						34.98	68
69	ELECTROCARDIOLOGY	28.19	17.73					45.92	69
69.01	EP LAB	32.65	24.86					57.51	69.01
69.02	VASCULAR SERVICES	28.47	23.72					52.19	69.02
70	ELECTROENCEPHALOGRAPHY	18.56	18.82					37.38	70
71	MEDICAL SUPPLIES CHARGED TO PAT	34.14	8.29					42.43	71
72	IMPL. DEV. CHARGED TO PATIENTS	39.10	13.20					52.30	72
73	DRUGS CHARGED TO PATIENTS	30.41	16.51					46.92	73
74	RENAL DIALYSIS	64.61	3.45					68.06	74
75	ASC (NON-DISTINCT PART)	4.56	37.84					42.40	75
76.01	OP ONCOLOGY		48.85					48.85	76.01
76.97	CARDIAC REHABILITATION		40.57					40.57	76.97
91	EMERGENCY	13.55	10.40					23.95	91
92	OBSERVATION BEDS (NON-DISTINCT	11.80	13.72					25.52	92
200	TOTAL CHARGES	22.65	14.08					36.73	200

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IRF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
41	SUBPROVIDER - IRF	75.72		5.38				81.10	41
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	0.03						0.03	50
51	RECOVERY ROOM	0.24						0.24	51
53	ANESTHESIOLOGY	0.02						0.02	53
54	RADIOLOGY-DIAGNOSTIC	0.46						0.46	54
55	RADIOLOGY-THERAPEUTIC	0.12						0.12	55
56	RADIOISOTOPE	0.12						0.12	56
57	CT SCAN	0.14						0.14	57
58	MRI	0.10						0.10	58
60	LABORATORY	0.84						0.84	60
65	RESPIRATORY THERAPY	1.15						1.15	65
66	PHYSICAL THERAPY	20.02						20.02	66
67	OCCUPATIONAL THERAPY	34.13						34.13	67
68	SPEECH PATHOLOGY	28.43						28.43	68
69	ELECTROCARDIOLOGY	0.16						0.16	69
69.01	EP LAB	1.50						1.50	69.01
70	ELECTROENCEPHALOGRAPHY	0.80						0.80	70
71	MEDICAL SUPPLIES CHARGED TO PAT	1.70						1.70	71
73	DRUGS CHARGED TO PATIENTS	1.34						1.34	73
74	RENAL DIALYSIS	3.66						3.66	74
200	TOTAL CHARGES	0.98						0.98	200

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,445,799	0.58	-1,445,799	-1.41			1
2	CAP REL COSTS-MVBLE EQUIP	7,147,245	2.88	-7,147,245	-6.95			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	798,248	0.32	-798,248	-0.78			4
5	ADMINISTRATIVE & GENERAL	54,862,636	22.11	-54,862,636	-53.38			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,010,426	4.84	-12,010,426	-11.68			7
8	LAUNDRY & LINEN SERVICE	2,429,397	0.98	-2,429,397	-2.36			8
9	HOUSEKEEPING	4,128,405	1.66	-4,128,405	-4.02			9
10	DIETARY	1,025,673	0.41	-1,025,673	-1.00			10
11	CAFETERIA	1,557,676	0.63	-1,557,676	-1.52			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,392,919	0.96	-2,392,919	-2.33			13
14	CENTRAL SERVICES & SUPPLY	928,534	0.37	-928,534	-0.90			14
15	PHARMACY	3,138,429	1.26	-3,138,429	-3.05			15
16	MEDICAL RECORDS & LIBRARY	2,859,353	1.15	-2,859,353	-2.78			16
17	SOCIAL SERVICE	679,147	0.27	-679,147	-0.66			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	2,415,541	0.97	-2,415,541	-2.35			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,967,640	2.00	-4,967,640	-4.83			22
23	PARAMED ED PRGM-(SPECIFY)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	26,956,259	10.86	32,684,999	31.80	59,641,258	24.04	30
31	INTENSIVE CARE UNIT	8,227,872	3.32	5,175,073	5.03	13,402,945	5.40	31
41	SUBPROVIDER - IRF	2,003,108	0.81	1,789,275	1.74	3,792,383	1.53	41
43	NURSERY	1,355,650	0.55	694,915	0.68	2,050,565	0.83	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,214,950	4.52	8,268,527	8.04	19,483,477	7.85	50
50.01	SURGICENTER	2,090,504	0.84	669,537	0.65	2,760,041	1.11	50.01
50.02	SURGERY RECOVERY CENTER	1,813,057	0.73	553,399	0.54	2,366,456	0.95	50.02
51	RECOVERY ROOM	1,635,323	0.66	665,246	0.65	2,300,569	0.93	51
53	ANESTHESIOLOGY	404,815	0.16	512,278	0.50	917,093	0.37	53
54	RADIOLOGY-DIAGNOSTIC	3,360,585	1.35	3,114,921	3.03	6,475,506	2.61	54
54.01	BREAST DIAGNOSIS CENTER	1,533,664	0.62	565,887	0.55	2,099,551	0.85	54.01
55	RADIOLOGY-THERAPEUTIC	1,705,635	0.69	1,510,850	1.47	3,216,485	1.30	55
56	RADIOISOTOPE	1,349,753	0.54	693,317	0.67	2,043,070	0.82	56
57	CT SCAN	1,831,088	0.74	1,079,036	1.05	2,910,124	1.17	57
58	MRI	1,160,036	0.47	495,453	0.48	1,655,489	0.67	58
59	CARDIAC CATHETERIZATION	4,201,203	1.69	1,603,151	1.56	5,804,354	2.34	59
60	LABORATORY	10,374,722	4.18	4,751,597	4.62	15,126,319	6.10	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,267,445	1.32	1,549,681	1.51	4,817,126	1.94	65
65.01	SLEEP LAB	328,209	0.13	231,094	0.22	559,303	0.23	65.01
66	PHYSICAL THERAPY	1,972,674	0.80	971,350	0.95	2,944,024	1.19	66
66.01	OP PHYSICAL THERAPY	1,005,391	0.41	315,800	0.31	1,321,191	0.53	66.01
66.02	OP THERAPY SERVICES	2,606,156	1.05	824,730	0.80	3,430,886	1.38	66.02
67	OCCUPATIONAL THERAPY	1,056,322	0.43	842,440	0.82	1,898,762	0.77	67
68	SPEECH PATHOLOGY	459,350	0.19	166,175	0.16	625,525	0.25	68
69	ELECTROCARDIOLOGY	1,426,592	0.57	1,454,392	1.41	2,880,984	1.16	69
69.01	EP LAB	506,544	0.20	492,135	0.48	998,679	0.40	69.01
69.02	VASCULAR SERVICES	330,084	0.13	124,286	0.12	454,370	0.18	69.02
70	ELECTROENCEPHALOGRAPHY	121,820	0.05	152,620	0.15	274,440	0.11	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,710,018	1.09	1,145,376	1.11	3,855,394	1.55	71
72	IMPL. DEV. CHARGED TO PATIENTS	7,156,150	2.88	3,051,036	2.97	10,207,186	4.11	72
73	DRUGS CHARGED TO PATIENTS	15,302,974	6.17	9,155,467	8.91	24,458,441	9.86	73
74	RENAL DIALYSIS	918,057	0.37	291,939	0.28	1,209,996	0.49	74
75	ASC (NON-DISTINCT PART)	1,575,891	0.64	2,248,031	2.19	3,823,922	1.54	75
76	WOUND CARE							76

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REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
76.01	OP ONCOLOGY	865,560	0.35	386,500	0.38	1,252,060	0.50	76.01
76.97	CARDIAC REHABILITATION	877,025	0.35	303,255	0.30	1,180,280	0.48	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
90.01	DIABETES CENTER							90.01
91	EMERGENCY	10,761,126	4.34	6,296,381	6.13	17,057,507	6.87	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
101	HOME HEALTH AGENCY	4,024,318	1.62	1,317,204	1.28	5,341,522	2.15	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	279,564	0.11	783,080	0.76	1,062,644	0.43	116
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	349,709	0.14	238,179	0.23	587,888	0.24	190
191	RESEARCH	60,204	0.02	370,108	0.36	430,312	0.17	191
192	PHYSICIANS' PRIVATE OFFICES	6,069,384	2.45	5,221,889	5.08	11,291,273	4.55	192
193	NONPAID WORKERS	25,725	0.01	8,317	0.01	34,042	0.01	193
194	DEVELOPMENT	59,356	0.02	18,142	0.02	77,498	0.03	194
194.01	SENIOR FRIENDS							194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	248,120,940	100.00			248,120,940	100.00	202

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,275,088	68,691,759	0.018562	13,648,103	253,336	50
50.01	SURGICENTER	42,700	5,305,594	0.008048			50.01
50.02	SURGERY RECOVERY CENTER	33,781	6,028,849	0.005603			50.02
51	RECOVERY ROOM	41,545	10,846,387	0.003830	1,763,493	6,754	51
53	ANESTHESIOLOGY	88,982	14,544,169	0.006118	2,838,637	17,367	53
54	RADIOLOGY-DIAGNOSTIC	564,642	41,914,431	0.013471	8,629,145	116,243	54
54.01	BREAST DIAGNOSIS CENTER	38,480	8,801,360	0.004372	14,633	64	54.01
55	RADIOLOGY-THERAPEUTIC	279,815	13,747,865	0.020353	354,062	7,206	55
56	RADIOISOTOPE	78,290	15,122,699	0.005177	2,225,967	11,524	56
57	CT SCAN	76,018	84,667,846	0.000898	16,089,360	14,448	57
58	MRI	30,117	22,187,421	0.001357	3,122,665	4,237	58
59	CARDIAC CATHETERIZATION	103,183	50,118,073	0.002059	17,033,745	35,072	59
60	LABORATORY	544,785	89,132,910	0.006112	27,388,038	167,396	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	126,173	24,434,521	0.005164	12,333,017	63,688	65
65.01	SLEEP LAB	36,460	3,030,337	0.012032	9,836	118	65.01
66	PHYSICAL THERAPY	130,333	9,839,964	0.013245	2,164,517	28,669	66
66.01	OP PHYSICAL THERAPY	19,190	5,103,307	0.003760			66.01
66.02	OP THERAPY SERVICES	50,204	14,058,880	0.003571			66.02
67	OCCUPATIONAL THERAPY	155,833	5,654,448	0.027559	1,471,204	40,545	67
68	SPEECH PATHOLOGY	12,455	2,137,252	0.005828	747,614	4,357	68
69	ELECTROCARDIOLOGY	252,361	23,423,038	0.010774	6,603,665	71,148	69
69.01	EP LAB	93,608	2,013,067	0.046500	657,305	30,565	69.01
69.02	VASCULAR SERVICES	7,952	3,638,710	0.002185	1,035,988	2,264	69.02
70	ELECTROENCEPHALOGRAPHY	28,962	1,371,365	0.021119	254,495	5,375	70
71	MEDICAL SUPPLIES CHARGED TO PAT	91,787	14,982,079	0.006126	5,114,703	31,333	71
72	IMPL. DEV. CHARGED TO PATIENTS	254,733	19,802,907	0.012863	7,742,613	99,593	72
73	DRUGS CHARGED TO PATIENTS	434,681	89,002,343	0.004884	27,066,512	132,193	73
74	RENAL DIALYSIS	17,725	5,323,151	0.003330	3,439,537	11,454	74
75	ASC (NON-DISTINCT PART)	473,876	4,352,145	0.108883	198,600	21,624	75
76	WOUND CARE						76
76.01	OP ONCOLOGY	29,517	5,979,770	0.004936			76.01
76.97	CARDIAC REHABILITATION	20,110	3,017,731	0.006664			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	DIABETES CENTER						90.01
91	EMERGENCY	714,731	102,067,715	0.007003	13,834,511	96,883	91
92	OBSERVATION BEDS (NON-DISTINCT	330,569	12,168,399	0.027166	1,435,325	38,992	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	6,478,686	782,510,492		177,217,290	1,312,448	200

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	2,738,380		2,738,380	59,519	46.01	28,776	1,323,984	30
31	INTENSIVE CARE UNIT	589,372		589,372	7,487	78.72	4,270	336,134	31
200	TOTAL	3,327,752		3,327,752	67,006		33,046	1,660,118	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	1,660,118
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	1,312,448
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	2,972,566
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	7,128
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	33,046
PER DISCHARGE CAPITAL COSTS	417.03

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 06/02/2014 Run Time: 16:57 Version: 2014.03

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	64,443,550
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	235,727,597
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.273

COST TO CHARGE RATIO FOR REHAB SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 41 + Worksheet D, Part IV, column 11, line 200))	4,872,716
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 41, column 2 plus Worksheet D-3, line 202, column 2)	13,086,123
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.372

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	2,972,566
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.013

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	22,271,132
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	109,933,283
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.203