

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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. ☒ Electronically filed cost report Date: 03/29/2019 Time: 15:23 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 01/01/2018 and ending 12/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				TITLE XIX	
		TITLE V	PART A	PART B	HIT		
		1	2	3	4	5	
1	HOSPITAL		605,168	67,193			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		-49,152	-12			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		556,016	67,181			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 OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this 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.

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care 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:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							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 OLTG									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 / 2018	To: 12 / 31 / 2018	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
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)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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		23

		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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,605	2,201	9	85	6,196	237	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		25			79		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.	2	11 / 09 / 2018	27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is 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 is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)			37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

		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)(i) or (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)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	Y	Y	40
		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
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N		58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N		59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N		60
		Y/N 1	IME 4	Direct GME 5
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 baseline 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. Enter in column 4, the 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. Enter in column 4 direct the 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	Y		63
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider 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 nonprovider 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)						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							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider 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 nonprovider 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		1.000000	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 is 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, indicate which program year began during this cost reporting period. (see instructions)				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 is 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, indicate which program year began during this cost reporting period. (see instructions)	Y	N		76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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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/IID 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	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. (see instructions)			107
	If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			
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
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	N	109
		Physical	Occupational	
			Speech	Respiratory

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	1	2	111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	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
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 (see instructions)	N		140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City: MISAWAKA	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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	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, chapter 40, §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	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N	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. (see instructions)					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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2018	09 / 28 / 2018		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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.	Y	A	05/31/2019	4
5	Are the cost report total expenses and total revenues different from those in 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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME 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

		Y/N	
Bad Debts		Y	
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

		Y	
Bed Complement		Y	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	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)	Y	03/07/2019	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
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
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 capitalization 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	Are 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 Report Preparer Contact Information			
41	First name: MICHAEL	Last name: CADDICK	Title: VICE PRESIDENT
42	Employer: STRATEGIC REIMBURSEMENT, INC.		
43	Phone number: 708 466-7240	E-mail Address: MICHAEL.CADDICK@SRINC.ORG	

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A 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	161	67,641			16,582	1,747	34,460	1
2	HMO and other (see instructions)						6,124	6,148		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						233	79		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)		161	67,641			16,582	1,747	34,460	7
8	Intensive Care Unit	31	31	12,252			3,357	1,747	8,113	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						407	2,528	13
14	Total (see instructions)		192	79,893			19,939	3,901	45,101	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41	14	9,052			2,031	25	2,822	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					14,821		22,758	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30							82	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		206							27
28	Observation Bed Days								13,726	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							237	359	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		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)					4,568	2,108	10,945	1
2	HMO and other (see instructions)					1,264			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)	98.83	1,230.16			4,568	2,108	10,945	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF	1.03	22.27			175	20	243	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		25.17						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)	99.86	1,277.60						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclass- ification 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	105,591,627		105,591,627	2,862,410.00	36.89	1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist Part B							3
4 Physician-Part A - Administrative		185,000		185,000	1,480.00	125.00	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	5,856,603	-511,618	5,344,985	205,564.00	26.00	7
7.01 Contracted interns & residents (in an approved program)		1,639,849		1,639,849	38,378.00	42.73	7.01
8 Home office and/or related organization personnel		21,860,497		21,860,497	473,920.00	46.13	8
9 SNF	44						9
10 Excluded area salaries (see instructions)		5,863,343	-147,474	5,715,869	186,978.00	30.57	10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		10,372,100		10,372,100	236,292.00	43.90	11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		286,576		286,576	2,388.00	120.01	13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries		19,087,345		19,087,345	530,204.00	36.00	14.01
14.02 Related organization salaries							14.02
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)		23,833,291		23,833,291			17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		1,766,357		1,766,357			19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative		57,170		57,170			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)		1,651,744		1,651,744			25
25.50 Home office wage-related		7,059,703		7,059,703			25.50
25.51 Related organization wage-related							25.51
25.52 Home office: Physician Part A - Administrative - wage-related							25.52
25.53 Home office & Contract Physicians Part A - Teaching - wage-related							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department		402,297		402,297	11,956.00	33.65	26
27 Administrative & General		26,134,515	-355,049	25,779,466	297,669.00	86.60	27
28 Administrative & General under contract (see instructions)		736,324		736,324	5,684.00	129.54	28
29 Maintenance & Repairs							29
30 Operation of Plant		2,405,106		2,405,106	76,389.00	31.48	30
31 Laundry & Linen Service		167,924		167,924	13,074.00	12.84	31
32 Housekeeping		2,444,707		2,444,707	167,732.00	14.58	32
33 Housekeeping under contract (see instructions)							33
34 Dietary		2,169,251	-1,704,667	464,584	27,354.00	16.98	34
35 Dietary under contract (see instructions)							35
36 Cafeteria			1,692,847	1,692,847	99,674.00	16.98	36
37 Maintenance of Personnel							37
38 Nursing Administration		1,248,158		1,248,158	26,695.00	46.76	38
39 Central Services and Supply							39
40 Pharmacy		3,092,932	-320	3,092,612	71,663.00	43.15	40
41 Medical Records & Medical Records Library		1,013,804		1,013,804	23,908.00	42.40	41
42 Social Service			514,343	514,343	14,660.00	35.08	42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1 Net salaries (see instructions)		76,971,002	511,618	77,482,620	2,150,232.00	36.03	1
2 Excluded area salaries (see instructions)		5,863,343	-147,474	5,715,869	186,978.00	30.57	2
3 Subtotal salaries (line 1 minus line 2)		71,107,659	659,092	71,766,751	1,963,254.00	36.56	3
4 Subtotal other wages & related costs (see instructions)		29,746,021		29,746,021	768,884.00	38.69	4
5 Subtotal wage-related costs (see instructions)		30,950,164		30,950,164		43.13%	5
6 Total (sum of lines 3 through 5)		131,803,844	659,092	132,462,936	2,732,138.00	48.48	6
7 Total overhead cost (see instructions)		39,815,018	147,154	39,962,172	836,458.00	47.78	7

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	6,265,417	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
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	9,039,077	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan	3,319,907	9
10	Dental, Hearing and Vision Plan	983,931	10
11	Life Insurance (If employee is owner or beneficiary)	50,856	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	647,938	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	198,738	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	6,556,884	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	159,592	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	86,226	23
24	Total Wage Related cost (Sum of lines 1-23)	27,308,566	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	11,609,656	165,464	1
2	Hospital	11,609,656	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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**HHA CCN: 14-7267****WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County:

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		339		182	521	1
2	Unduplicated Census Count (see instructions)		731.00		392.00	1,123.00	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 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)	2.00		2.00	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	6.52		6.52	5
6	Direct Nursing Service	11.36		11.36	6
7	Nursing Supervisor				7
8	Physical Therapy Service	2.98	5.04	8.02	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service		2.98	2.98	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	0.12		0.12	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.64	1.37	2.01	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.59		1.59	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	16974	20

PPS ACTIVITY

		Full Episodes					
		Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4	Total (columns 1 through 4) 5	
21	Skilled Nursing Visits	5,773	517	327	192	6,809	21
22	Skilled Nursing Visit Charges	2,162,762	193,708	122,718	71,796	2,550,984	22
23	Physical Therapy Visits	4,735	63	50	192	5,040	23
24	Physical Therapy Visit Charges	1,841,254	24,418	19,500	74,481	1,959,653	24
25	Occupational Therapy Visits	1,623	46	16	69	1,754	25
26	Occupational Therapy Visit Charges	632,249	17,921	6,240	26,853	683,263	26
27	Speech Pathology Visits	80	6		2	88	27
28	Speech Pathology Visit Charges	31,124	2,340		761	34,225	28
29	Medical Social Service Visits	98	5	4	3	110	29
30	Medical Social Service Visit Charges	44,230	2,260	1,808	1,356	49,654	30
31	Home Health Aide Visits	881	123	3	13	1,020	31
32	Home Health Aide Visit Charges	159,550	22,377	537	2,303	184,767	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	13,190	760	400	471	14,821	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	4,871,169	263,024	150,803	177,550	5,462,546	35
36	Total Number of Episodes (standard/non-outlier)	821		145	33	999	36
37	Total Number of Ourlier Episodes		23		2	25	37
38	Total Non-Routine Medical Supply Charges	166,678	26,655	30,165	1,567	225,065	38

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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)	0.201299	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	44,472,950	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	218,194,905	6
7	Medicaid cost (line 1 times line 6)	43,922,416	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.		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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng 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)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	38,556,590	5,459,955	44,016,545	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,761,403	5,459,955	13,221,358	21
22	Payments received from patients for amounts previously written off as charity care	181,501	146,986	328,487	22
23	Cost of charity care (line 21 minus line 22)	7,579,902	5,312,969	12,892,871	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	31,568,155	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,855,705	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,854,931	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	28,713,224	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	6,779,169	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	19,672,040	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	19,672,040	31

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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		11,756,795	11,756,795	4,102,305	15,859,100	-3,675,451	12,183,649	1
2	00200	Cap Rel Costs-Mvble Equip		17,097,695	17,097,695	421,016	17,518,711	-8,688,953	8,829,758	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	402,297	1,011,673	1,413,970		1,413,970	1,946,207	3,360,177	4
5	00500	Administrative & General	26,134,515	69,197,538	95,332,053	-1,506,501	93,825,552	-31,289,829	62,535,723	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,405,106	11,873,852	14,278,958	-224,213	14,054,745	-1,036,479	13,018,266	7
8	00800	Laundry & Linen Service	167,924	931,708	1,099,632		1,099,632		1,099,632	8
9	00900	Housekeeping	2,444,707	1,843,140	4,287,847	-24,078	4,263,769		4,263,769	9
10	01000	Dietary	2,169,251	1,364,916	3,534,167	-2,783,355	750,812	-311,228	439,584	10
11	01100	Cafeteria				2,758,004	2,758,004	-685,123	2,072,881	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,248,158	379,099	1,627,257		1,627,257		1,627,257	13
14	01400	Central Services & Supply		2,050,225	2,050,225	-1,848,089	202,136	-170,447	31,689	14
15	01500	Pharmacy	3,092,932	16,666,811	19,759,743	-15,618,602	4,141,141	-188,366	3,952,775	15
16	01600	Medical Records & Library	1,013,804	535,394	1,549,198		1,549,198	-30,970	1,518,228	16
17	01700	Social Service				657,856	657,856		657,856	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	5,856,603		5,856,603	-511,618	5,344,985		5,344,985	21
22	02200	I&R Services-Other Prgm Costs Apprvd		3,980,962	3,980,962	511,618	4,492,580		4,492,580	22
23	02300	Paramed Ed Prgm-(specify)								23
23.01	02301	RADIOLOGY PARAMEDICAL								23.01
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	19,458,939	8,055,139	27,514,078	-4,261,492	23,252,586	-1,368,432	21,884,154	30
31	03100	Intensive Care Unit	6,927,743	3,616,141	10,543,884	37,500	10,581,384	-631,661	9,949,723	31
41	04100	Subprovider - IRF	1,557,713	527,135	2,084,848		2,084,848	-8,702	2,076,146	41
43	04300	Nursery				1,261,587	1,261,587		1,261,587	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	4,349,567	14,167,933	18,517,500	-9,927,500	8,590,000	-353,764	8,236,236	50
50.01	05001	SURGICENTER								50.01
50.02	05002	SURGERY RECOVERY CENTER		1,379,882	1,379,882	-190,457	1,189,425	-1,860	1,187,565	50.02
51	05100	Recovery Room	860,148	3,429	863,577		863,577		863,577	51
53	05300	Anesthesiology		3,865,715	3,865,715		3,865,715	-3,439,893	425,822	53
54	05400	Radiology-Diagnostic	2,230,752	774,555	3,005,307	-45,332	2,959,975	-112,043	2,847,932	54
54.01	05401	BREAST DIAGNOSIS CENTER	594,109	339,804	933,913	-131,035	802,878		802,878	54.01
55	05500	Radiology-Therapeutic	791,058	693,040	1,484,098		1,484,098	-420	1,483,678	55
56	05600	Radioisotope	477,106	645,671	1,122,777		1,122,777		1,122,777	56
57	05700	CT Scan	937,847	879,390	1,817,237	-213,486	1,603,751	-6,305	1,597,446	57
58	05800	MRI	598,160	373,718	971,878		971,878		971,878	58
59	05900	Cardiac Catheterization	1,529,453	5,698,322	7,227,775	-3,938,898	3,288,877	-1,498	3,287,379	59
60	06000	Laboratory		10,409,366	10,409,366	48,000	10,457,366	-66,771	10,390,595	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	2,153,062	1,113,836	3,266,898	-239,293	3,027,605	-5,115	3,022,490	65
65.01	06501	SLEEP LAB	293,180	128,495	421,675	3,901	425,576	-10,755	414,821	65.01
66	06600	Physical Therapy	45,142	2,685,524	2,730,666		2,730,666		2,730,666	66
66.01	06601	OP PHYSICAL THERAPY		1,359,141	1,359,141		1,359,141		1,359,141	66.01
66.02	06602	OP THERAPY SERVICES		3,127,567	3,127,567	-399,309	2,728,258		2,728,258	66.02
67	06700	Occupational Therapy		1,108,302	1,108,302		1,108,302		1,108,302	67
68	06800	Speech Pathology	379,621	114,697	494,318		494,318		494,318	68
69	06900	Electrocardiology	1,441,748	538,562	1,980,310	-535,840	1,444,470	-14,504	1,429,966	69
69.01	06901	EP LAB								69.01
69.02	03650	VASCULAR SERVICES								69.02
70	07000	Electroencephalography	116,447	61,948	178,395		178,395		178,395	70
71	07100	Medical Supplies Charged to Patients				10,943,945	10,943,945		10,943,945	71
72	07200	Impl. Dev. Charged to Patients				5,913,076	5,913,076		5,913,076	72
73	07300	Drugs Charged to Patients				15,618,187	15,618,187		15,618,187	73
74	07400	Renal Dialysis		1,638,619	1,638,619		1,638,619		1,638,619	74
75	07500	ASC (Non-Distinct Part)	1,397,224	80,722	1,477,946		1,477,946		1,477,946	75
76	03951	WOUND CARE								76
76.01	03952	OP ONCOLOGY	614,839	230,801	845,640	3,115,497	3,961,137	-54,992	3,906,145	76.01
76.97	07697	CARDIAC REHABILITATION	711,819	218,193	930,012	182,504	1,112,516	-184	1,112,332	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	909,627	686,487	1,596,114	415	1,596,529	-102,263	1,494,266	90
90.01	09001	URGENT CARE CENTER	501,651	826,337	1,327,988		1,327,988		1,327,988	90.01
91	09100	Emergency	7,473,745	3,712,104	11,185,849	281,799	11,467,648	-403,400	11,064,248	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	2,136,076	1,499,954	3,636,030	-203,896	3,432,134		3,432,134	101

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		3,590,583	3,590,583	-3,590,583				113
118		SUBTOTALS (sum of lines 1-117)	103,422,073	212,840,920	316,262,993	-336,367	315,926,626	-50,713,201	265,213,425	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	41,982	215,996	257,978		257,978		257,978	190
192	19200	Physicians' Private Offices	2,127,572	5,058,681	7,186,253	317,110	7,503,363		7,503,363	192
193	19300	Nonpaid Workers		5,533	5,533	19,257	24,790		24,790	193
194	07950	DEVELOPMENT		840	840		840		840	194
194.01	07951	NON ALLOWABLE HOSPICE		28,065	28,065		28,065		28,065	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)	105,591,627	218,150,035	323,741,662		323,741,662	-50,713,201	273,028,461	200

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
1	RENT/LEASE EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		414,467
2			Cap Rel Costs-Mvble Equip	2		389,349
3						
4						
5						
6						
7						
8						
500	Total reclassifications					803,816
	Code Letter - A					
1	CHARGEABLE SUPPLIES	B	Medical Supplies Charged to P	71		10,943,945
2						
3						
4						
5						
6						
7						
8						
500	Total reclassifications					10,943,945
	Code Letter - B					
1	CLINIC COSTS	C	Clinic	90	320	95
500	Total reclassifications				320	95
	Code Letter - C					
1	COST OF DRUGS SOLD	D	Drugs Charged to Patients	73		15,618,187
500	Total reclassifications					15,618,187
	Code Letter - D					
1	SOCIAL SERVICES	E	Social Service	17	514,343	143,513
500	Total reclassifications				514,343	143,513
	Code Letter - E					
1	INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		3,590,583
500	Total reclassifications					3,590,583
	Code Letter - F					
1	CAFETERIA COSTS	G	Cafeteria	11	1,692,847	1,065,157
2			Nonpaid Workers	193	11,820	7,437
500	Total reclassifications				1,704,667	1,072,594
	Code Letter - G					
1	PROFESSIONAL FEES	I	Radiology-Diagnostic	54		46,259
2			Laboratory	60		48,000
500	Total reclassifications					94,259
	Code Letter - I					
1	HHA OVERHEAD COSTS	J	Administrative & General	5	159,294	44,602
500	Total reclassifications				159,294	44,602
	Code Letter - J					
1	PROPERTY INSURANCE	K	Cap Rel Costs-Bldg & Fixt	1		190,778
2			Cap Rel Costs-Mvble Equip	2		31,667
500	Total reclassifications					222,445
	Code Letter - K					
1	NURSERY COSTS	L	Nursery	43	932,256	329,331
500	Total reclassifications				932,256	329,331
	Code Letter - L					
1	DIRECTOR FEES	M	Adults & Pediatrics	30		60,600
2			Intensive Care Unit	31		37,500
3			SLEEP LAB	65.01		7,500
4			OP ONCOLOGY	76.01		54,992
5			Emergency	91		403,485
500	Total reclassifications					564,077
	Code Letter - M					
1	CARDIAC ADMIN	N	Cardiac Catheterization	59	244,997	108,339
2			CARDIAC REHABILITATION	76.97	126,545	55,959
500	Total reclassifications				371,542	164,298
	Code Letter - N					
1	INTERSN RESIDENTS	O	I&R Services-Other Prgm Costs	22	511,618	
500	Total reclassifications				511,618	

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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
	Code Letter - O					
1	ONCOLOGY COSTS	P	OP ONCOLOGY	76.01	2,278,358	782,147
500	Total reclassifications				2,278,358	782,147
	Code Letter - P					
1	CHICAGO HEIGHTS POB COSTS	S	Physicians' Private Offices	192		317,110
2						
500	Total reclassifications					317,110
	Code Letter - S					
1	IMPLANT SUPPLY COSTS	T	Impl. Dev. Charged to Patient	72		5,913,076
2						
500	Total reclassifications					5,913,076
	Code Letter - T					
	GRAND TOTAL (Increases)				6,472,398	40,604,078

(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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	RENT/LEASE EXPENSE	A	Administrative & General	5		171,760	9	1
2			Operation of Plant	7		626	9	2
3			Housekeeping	9		24,078		3
4			Dietary	10		6,094		4
5			SURGERY RECOVERY CENTER	50.02		190,457		5
6			Respiratory Therapy	65		7,893		6
7			SLEEP LAB	65.01		3,599		7
8			OP THERAPY SERVICES	66.02		399,309		8
500	Total reclassifications					803,816		500
	Code letter - A							
1	CHARGEABLE SUPPLIES	B	Operating Room	50		5,780,610		1
2			Central Services & Supply	14		1,848,089		2
3			BREAST DIAGNOSIS CENTER	54.01		131,035		3
4			CT Scan	57		213,486		4
5			Cardiac Catheterization	59		2,526,048		5
6			Respiratory Therapy	65		231,400		6
7			Emergency	91		121,686		7
8			Radiology-Diagnostic	54		91,591		8
500	Total reclassifications					10,943,945		500
	Code letter - B							
1	CLINIC COSTS	C	Pharmacy	15	320	95		1
500	Total reclassifications				320	95		500
	Code letter - C							
1	COST OF DRUGS SOLD	D	Pharmacy	15		15,618,187		1
500	Total reclassifications					15,618,187		500
	Code letter - D							
1	SOCIAL SERVICES	E	Administrative & General	5	514,343	143,513		1
500	Total reclassifications				514,343	143,513		500
	Code letter - E							
1	INTEREST	F	Interest Expense	113		3,590,583	9	1
500	Total reclassifications					3,590,583		500
	Code letter - F							
1	CAFETERIA COSTS	G	Dietary	10	1,704,667	1,072,594		1
2								2
500	Total reclassifications				1,704,667	1,072,594		500
	Code letter - G							
1	PROFESSIONAL FEES	I	Administrative & General	5		94,259		1
2								2
500	Total reclassifications					94,259		500
	Code letter - I							
1	HHA OVERHEAD COSTS	J	Home Health Agency	101	159,294	44,602		1
500	Total reclassifications				159,294	44,602		500
	Code letter - J							
1	PROPERTY INSURANCE	K	Administrative & General	5		222,445	9	1
2							9	2
500	Total reclassifications					222,445		500
	Code letter - K							
1	NURSERY COSTS	L	Adults & Pediatrics	30	932,256	329,331		1
500	Total reclassifications				932,256	329,331		500
	Code letter - L							
1	DIRECTOR FEES	M	Administrative & General	5		564,077		1
2								2
3								3
4								4
5								5
500	Total reclassifications					564,077		500
	Code letter - M							
1	CARDIAC ADMIN	N	Electrocardiology	69	371,542	164,298		1
2								2
500	Total reclassifications				371,542	164,298		500
	Code letter - N							
1	INTERSN RESIDENTS	O	I&R Services-Salary & Fringes	21	511,618			1

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
500	Total reclassifications				511,618			500
	Code letter - O							
1	ONCOLOGY COSTS	P	Adults & Pediatrics	30	2,278,358	782,147		1
500	Total reclassifications				2,278,358	782,147		500
	Code letter - P							
1	CHICAGO HEIGHTS POB COSTS	S	Cap Rel Costs-Bldg & Fixt	1		93,523	9	1
2			Operation of Plant	7		223,587		2
500	Total reclassifications					317,110		500
	Code letter - S							
1	IMPLANT SUPPLY COSTS	T	Operating Room	50		4,146,890		1
2			Cardiac Catheterization	59		1,766,186		2
500	Total reclassifications					5,913,076		500
	Code letter - T							
	GRAND TOTAL (Decreases)				6,472,398	40,604,078		

(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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	7,320,500				525,000	6,795,500		1
2	Land Improvements	4,286,323	51,691		51,691	1,450,490	2,887,524		2
3	Buildings and Fixtures	215,777,700	128,249,624		128,249,624	68,037,736	275,989,588		3
4	Building Improvements	1,075,647					1,075,647		4
5	Fixed Equipment								5
6	Movable Equipment	92,584,651	13,894,355		13,894,355	28,745,939	77,733,067		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	321,044,821	142,195,670		142,195,670	98,759,165	364,481,326		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	321,044,821	142,195,670		142,195,670	98,759,165	364,481,326		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	11,756,795						11,756,795	1
2	Cap Rel Costs-Mvble Equip	17,097,695						17,097,695	2
3	Total (sum of lines 1-2)	28,854,490						28,854,490	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 line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble Equip				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	12,183,649						12,183,649	1
2	Cap Rel Costs-Mvble Equip	8,829,758						8,829,758	2
3	Total (sum of lines 1-2)	21,013,407						21,013,407	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.)

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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ADJUSTMENTS TO EXPENSES
WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-408,086	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	-161,572	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	-12,706,487				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-170,447	Central Services & Supply	14		16
17	Sale of drugs to other than patients	B	-188,366	Pharmacy	15		17
18	Sale of medical records and abstracts	B	-30,970	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-58,473	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						32
33							33
33.05	CAFETERIA REVENUE	B	-685,123	Cafeteria	11		33.05
33.15	PATIENT PHONE COSTS	A	-139,998	Administrative & General	5		33.15
33.17	PATIENT TV COSTS	A	-3,647	Cap Rel Costs-Mvble Equip	2	9	33.17
33.18	PATIENT TV COSTS/REPAIRS	A	-6,715	Administrative & General	5		33.18
33.19	PROPERTY TAXES	A	-1,036,479	Operation of Plant	7		33.19
33.45	1500 FEES	A	-53,052	Administrative & General	5		33.45
33.46	PHYSICIAN SUBSIDIES	A	-488,530	Administrative & General	5		33.46
33.61	MARKETING COSTS	A	-1,686,423	Administrative & General	5		33.61
33.73	PRINT SHOP FEES	B	-120	Administrative & General	5		33.73
33.78	TELECOMMUNICATIONS REVENUE	B	-58,523	Administrative & General	5		33.78
33.79	BABY PHOTOS	B	-36	Adults & Pediatrics	30		33.79
33.82	RADIOLOGY PROGRAM FEES	B	-63,209	Radiology-Diagnostic	54		33.82
33.87	NON-ALLOWABLE ADMIN EXPENSES	A	-152,550	Administrative & General	5		33.87
33.89	INTEREST EXPENSE	A	-2,778,093	Cap Rel Costs-Bldg & Fixt	1	9	33.89
33.95	EMPLOYEE BADGES	B	-30	Administrative & General	5		33.95
33.98	SPECIAL FUNCTION MEALS	B	-17,918	Dietary	10		33.98
34	OTHER REVENUE	B	-9,550	Electrocardiology	69		34
34.01	DIETARY DISCOUNTS/REBATES	B	-234,837	Dietary	10		34.01
34.08	RENTAL REVENUE	B	-9,407	Cap Rel Costs-Bldg & Fixt	1	9	34.08
34.09	OTHER MISCELLANEOUS REVENUE	B	-168,210	Administrative & General	5		34.09
34.11	MEDICAID TAX	A	-13,577,567	Administrative & General	5		34.11
34.17	RESEARCH COSTS	A	-2,341	Operating Room	50		34.17
34.19	PENSION COSTS	A	1,946,207	Employee Benefits Department	4		34.19
34.20	OTHER REVENUE	B	-420	Radiology-Therapeutic	55		34.20
34.21	REBATES AND DISCOUNTS	B	-351,423	Operating Room	50		34.21
34.22	OTHER REVENUE	B	-18,875	Laboratory	60		34.22
34.23	OTHER REVENUE	B	-5,115	Respiratory Therapy	65		34.23
35	DIABETES COSTS	A	-150	Administrative & General	5		35
35.15	MISC REVENUE	B	-1,498	Cardiac Catheterization	59		35.15
35.16	LOBBYING COSTS	A	-351,353	Administrative & General	5		35.16
35.17	NON ALLOWABLE DUES	A	-68,644	Administrative & General	5		35.17
35.18	DEMOLITION COSTS	A	-7,800,000	Administrative & General	5		35.18

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
35.19	ACCELERATED DEPRECIATION	A	-8,700,000	Cap Rel Costs-Mvble Equip	2	9	35.19
36							36
37							37
38							38
39							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)		-50,713,201				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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
	1	2	3	Name	Percentage of Ownership	Type of Business	
6				4	5	6	6
7							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:

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen AGGREGATE	6,787,669	6,482,669	305,000	177,200	2,480	211,277	10,564	1
2	30	Adults & Pediatrics AGGREGATE	1,411,418	1,350,818	60,600	177,200	505	43,022	2,151	2
3	31	Intensive Care Unit AGGREGATE	658,326	620,826	37,500	177,200	313	26,665	1,333	3
4	41	Subprovider - IRF AGGREGATE	30,000		30,000	177,200	250	21,298	1,065	4
5	50	Operating Room AGGREGATE								5
6	22	I&R Services-Other P AGGREGATE								6
7	54	Radiology-Diagnostic AGGREGATE	48,919	46,259	2,660	177,200	1	85	4	7
8	60	Laboratory AGGREGATE	48,000		48,000	215,700	1	104	5	8
9	50.02	SURGERY RECOVERY CEN AGGREGATE	11,160		11,160	208,000	93	9,300	465	9
10	69	Electrocardiology AGGREGATE	16,966		16,966	177,200	141	12,012	601	10
11	65.01	SLEEP LAB AGGREGATE	37,165		37,165	177,200	310	26,410	1,321	11
12	90	Clinic AGGREGATE	102,263	102,263						12
13	76.01	OP ONCOLOGY AGGREGATE	54,992	54,992						13
14	76.97	CARDIAC REHABILITATI AGGREGATE	525		525	177,200	4	341	17	14
15	53	Anesthesiology AGGREGATE	3,439,893	3,439,893						15
16	91	Emergency AGGREGATE	403,485		403,485	177,200	1	85	4	16
17	57	CT Scan AGGREGATE	6,305	6,305						17
18										18
19										19
20										20
200		TOTAL	13,057,086	12,104,025	953,061		4,099	350,599	17,530	200

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen AGGREGATE					211,277	93,723	6,576,392	1
2	30	Adults & Pediatrics AGGREGATE					43,022	17,578	1,368,396	2
3	31	Intensive Care Unit AGGREGATE					26,665	10,835	631,661	3
4	41	Subprovider - IRF AGGREGATE					21,298	8,702	8,702	4
5	50	Operating Room AGGREGATE								5
6	22	I&R Services-Other P AGGREGATE								6
7	54	Radiology-Diagnostic AGGREGATE					85	2,575	48,834	7
8	60	Laboratory AGGREGATE					104	47,896	47,896	8
9	50.02	SURGERY RECOVERY CEN AGGREGATE					9,300	1,860	1,860	9
10	69	Electrocardiology AGGREGATE					12,012	4,954	4,954	10
11	65.01	SLEEP LAB AGGREGATE					26,410	10,755	10,755	11
12	90	Clinic AGGREGATE							102,263	12
13	76.01	OP ONCOLOGY AGGREGATE							54,992	13
14	76.97	CARDIAC REHABILITATI AGGREGATE					341	184	184	14
15	53	Anesthesiology AGGREGATE							3,439,893	15
16	91	Emergency AGGREGATE					85	403,400	403,400	16
17	57	CT Scan AGGREGATE							6,305	17
18										18
19										19
20										20
200		TOTAL					350,599	602,462	12,706,487	200

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	12,183,649	12,183,649					1
2	Cap Rel Costs-Mvble Equip	8,829,758		8,829,758				2
4	Employee Benefits Department	3,360,177	35,749	25,908	3,421,834			4
5	Administrative & General	62,535,723	1,354,270	981,469	838,631	65,710,093	65,710,093	5
6	Maintenance & Repairs							6
7	Operation of Plant	13,018,266	1,906,416	1,381,624	78,238	16,384,544	5,193,130	7
8	Laundry & Linen Service	1,099,632	53,071	38,462	5,463	1,196,628	379,275	8
9	Housekeeping	4,263,769	255,501	185,167	79,526	4,783,963	1,516,291	9
10	Dietary	439,584	90,468	65,564	15,113	610,729	193,572	10
11	Cafeteria	2,072,881	324,510	235,180	55,068	2,687,639	851,855	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,627,257	23,937	17,347	40,603	1,709,144	541,718	13
14	Central Services & Supply	31,689	474,365	343,783		849,837	269,358	14
15	Pharmacy	3,952,775	89,339	64,746	100,603	4,207,463	1,333,568	15
16	Medical Records & Library	1,518,228	69,378	50,280	32,979	1,670,865	529,586	16
17	Social Service	657,856	6,903	5,003	16,732	686,494	217,586	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	5,344,985	96,576	69,991	173,872	5,685,424	1,802,012	21
22	I&R Services-Other Prgrm Costs Apprvd	4,492,580			16,643	4,509,223	1,429,212	22
23	Paramed Ed Prgrm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,884,154	1,713,216	1,241,605	528,558	25,367,533	8,040,233	30
31	Intensive Care Unit	9,949,723	472,325	342,304	225,359	10,989,711	3,483,222	31
41	Subprovider - IRF	2,076,146	129,479	93,836	50,672	2,350,133	744,882	41
43	Nursery	1,261,587	72,432	52,493	30,326	1,416,838	449,071	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,236,236	854,309	619,136	141,491	9,851,172	3,122,359	50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER	1,187,565				1,187,565	376,402	50.02
51	Recovery Room	863,577	54,777	39,698	27,981	986,033	312,526	51
53	Anesthesiology	425,822	96,334	69,816		591,972	187,627	53
54	Radiology-Diagnostic	2,847,932	522,158	378,419	72,566	3,821,075	1,211,101	54
54.01	BREAST DIAGNOSIS CENTER	802,878	84,130	60,971	19,326	967,305	306,590	54.01
55	Radiology-Therapeutic	1,483,678	103,134	74,743	25,733	1,687,288	534,791	55
56	Radioisotope	1,122,777	35,611	25,808	15,520	1,199,716	380,254	56
57	CT Scan	1,597,446	24,179	17,523	30,508	1,669,656	529,202	57
58	MRI	971,878	61,588	44,634	19,458	1,097,558	347,874	58
59	Cardiac Catheterization	3,287,379	148,495	107,617	57,723	3,601,214	1,141,416	59
60	Laboratory	10,390,595	344,344	249,554		10,984,493	3,481,568	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,022,490	47,885	34,703	70,039	3,175,117	1,006,363	65
65.01	SLEEP LAB	414,821	11,525	8,352	9,537	444,235	140,802	65.01
66	Physical Therapy	2,730,666	209,253	151,650	1,468	3,093,037	980,347	66
66.01	OP PHYSICAL THERAPY	1,359,141	5,762	4,176		1,369,079	433,934	66.01
66.02	OP THERAPY SERVICES	2,728,258				2,728,258	864,730	66.02
67	Occupational Therapy	1,108,302	76,397	55,366		1,240,065	393,042	67
68	Speech Pathology	494,318	12,032	8,720	12,349	527,419	167,167	68
69	Electrocardiology	1,429,966	338,916	245,620	34,814	2,049,316	649,537	69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography	178,395	12,066	8,745	3,788	202,994	64,340	70
71	Medical Supplies Charged to Patients	10,943,945				10,943,945	3,468,716	71
72	Impl. Dev. Charged to Patients	5,913,076				5,913,076	1,874,167	72
73	Drugs Charged to Patients	15,618,187				15,618,187	4,950,231	73
74	Renal Dialysis	1,638,619	12,066	8,745		1,659,430	525,961	74
75	ASC (Non-Distinct Part)	1,477,946	314,576	227,980	45,452	2,065,954	654,810	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	3,906,145	42,883	31,078	94,116	4,074,222	1,291,337	76.01
76.97	CARDIAC REHABILITATION	1,112,332			27,272	1,139,604	361,201	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,494,266	28,812	20,880	29,601	1,573,559	498,744	90
90.01	URGENT CARE CENTER	1,327,988			16,319	1,344,307	426,082	90.01
91	Emergency	11,064,248	442,188	320,464	243,121	12,070,021	3,825,629	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,432,134			64,305	3,496,439	1,108,207	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
118	SUBTOTALS (sum of lines 1-117)	265,213,425	11,051,355	8,009,160	3,350,873	263,189,572	62,591,628	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	257,978	72,363	52,443	1,366	384,150	121,757	190
192	Physicians' Private Offices	7,503,363	877,727	636,108	69,210	9,086,408	2,879,964	192
193	Nonpaid Workers	24,790	79,301	57,471	385	161,947	51,330	193
194	DEVELOPMENT	840				840	266	194
194.01	NON ALLOWABLE HOSPICE	28,065	102,903	74,576		205,544	65,148	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 Centers							201
202	TOTAL (sum of lines 118-201)	273,028,461	12,183,649	8,829,758	3,421,834	273,028,461	65,710,093	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
	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	21,577,674						7
8	Laundry & Linen Service	128,853	1,704,756					8
9	Housekeeping	620,342		6,920,596				9
10	Dietary	219,652		72,983	1,096,936			10
11	Cafeteria	787,894		261,790		4,589,178		11
12	Maintenance of Personnel							12
13	Nursing Administration	58,117		19,310		54,209	2,382,498	13
14	Central Services & Supply	1,151,733		382,682				14
15	Pharmacy	216,910		72,072		145,526		15
16	Medical Records & Library	168,447		55,969		48,550		16
17	Social Service	16,761		5,569		29,770		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	234,482		77,910		607,243		21
22	I&R Services-Other Prgm Costs Apprvd					40,086		22
23	Paramed Ed Prgm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,159,597	1,238,377	1,382,093	796,842	1,057,023	886,389	30
31	Intensive Care Unit	1,146,780	288,548	381,036	185,668	380,991	319,487	31
41	Subprovider - IRF	314,368	100,368	104,454	64,582	94,048	78,865	41
43	Nursery	175,862		58,433		50,148	42,053	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,074,216		689,191		296,370	248,527	50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	Recovery Room	132,994		44,190		39,576	33,187	51
53	Anesthesiology	233,895		77,715				53
54	Radiology-Diagnostic	1,267,771		421,237		117,447		54
54.01	BREAST DIAGNOSIS CENTER	204,262		67,869		42,192		54.01
55	Radiology-Therapeutic	250,403		83,201		36,754		55
56	Radioisotope	86,462		28,728		20,985		56
57	CT Scan	58,704		19,506		49,466		57
58	MRI	149,531		49,684		27,908		58
59	Cardiac Catheterization	360,537		119,794		90,177		59
60	Laboratory	836,049		277,791				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	116,262		38,630		126,965	106,469	65
65.01	SLEEP LAB	27,981		9,297		17,882		65.01
66	Physical Therapy	508,054		168,809		4,437		66
66.01	OP PHYSICAL THERAPY	13,991		4,649				66.01
66.02	OP THERAPY SERVICES							66.02
67	Occupational Therapy	185,487		61,631				67
68	Speech Pathology	29,212		9,706		17,795		68
69	Electrocardiology	822,870		273,412		57,785	48,457	69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography	29,296		9,734		8,555	7,174	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	29,296		9,734				74
75	ASC (Non-Distinct Part)	763,774		253,776		69,698	58,446	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	104,118		34,595		186,103	156,060	76.01
76.97	CARDIAC REHABILITATION					46,578		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	69,953		23,243		37,613		90
90.01	URGENT CARE CENTER					36,508		90.01
91	Emergency	1,073,609		356,724		473,883	397,384	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency					97,561		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	18,828,525	1,627,293	6,007,147	1,047,092	4,409,832	2,382,498	118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
190	Gift, Flower, Coffee Shop & Canteen	175,694		58,377		9,812		190
192	Physicians' Private Offices	2,131,073		708,083		168,121		192
193	Nonpaid Workers	192,538		63,974		1,413		193
194	DEVELOPMENT							194
194.01	NON ALLOWABLE HOSPICE	249,844	77,463	83,015	49,844			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 Centers							201
202	TOTAL (sum of lines 118-201)	21,577,674	1,704,756	6,920,596	1,096,936	4,589,178	2,382,498	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	2,653,610						14
15	Pharmacy	4,517	5,980,056					15
16	Medical Records & Library			2,473,417				16
17	Social Service	13			956,193			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					8,407,071		21
22	I&R Services-Other Prgm Costs Apprvd						5,978,521	22
23	Paramed Ed Prgm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	86,340	4,330	212,479	691,285	8,278,609	5,887,168	30
31	Intensive Care Unit	61,029	5,532	59,956	161,073			31
41	Subprovider - IRF	4,353	123	11,646	56,027	128,462	91,353	41
43	Nursery			11,632				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	99,432	13,912	146,126				50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER	7		6,619				50.02
51	Recovery Room	262	19	23,534				51
53	Anesthesiology	48,577	879	55,427				53
54	Radiology-Diagnostic	228	180	105,795				54
54.01	BREAST DIAGNOSIS CENTER		49	18,257				54.01
55	Radiology-Therapeutic	1,167	68	32,854				55
56	Radioisotope	56,884	49	38,979				56
57	CT Scan	4,106	1,980	258,820				57
58	MRI	12,291	14	60,952				58
59	Cardiac Catheterization	7,613	587	93,304				59
60	Laboratory	115,919		249,860				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	11,089	26,830	100,710				65
65.01	SLEEP LAB	1,137		8,990				65.01
66	Physical Therapy	1,038	24	34,121				66
66.01	OP PHYSICAL THERAPY	730		16,917				66.01
66.02	OP THERAPY SERVICES	1,484	216	33,932				66.02
67	Occupational Therapy	2,490		14,476				67
68	Speech Pathology			6,814				68
69	Electrocardiology	2,016	27	72,237				69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography	905		3,884				70
71	Medical Supplies Charged to Patients	1,262,282		76,632				71
72	Impl. Dev. Charged to Patients	682,020		29,927				72
73	Drugs Charged to Patients		5,882,460	294,560				73
74	Renal Dialysis	2,047	107	10,997				74
75	ASC (Non-Distinct Part)	6,892		11,016				75
76	WOUND CARE							76
76.01	OP ONCOLOGY	5,015	2,976	47,402				76.01
76.97	CARDIAC REHABILITATION	329		6,411				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,121	32,138	6,644				90
90.01	URGENT CARE CENTER	3,895	2,743	1,519				90.01
91	Emergency	98,572	3,526	291,521	47,808			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	9,448	656	18,467				101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	2,595,248	5,979,425	2,473,417	956,193	8,407,071	5,978,521	118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	56,232	22					192
193	Nonpaid Workers							193
194	DEVELOPMENT							194
194.01	NON ALLOWABLE HOSPICE	2,130	609					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 Centers							201
202	TOTAL (sum of lines 118-201)	2,653,610	5,980,056	2,473,417	956,193	8,407,071	5,978,521	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	58,088,298	-14,165,777	43,922,521			30
31	Intensive Care Unit	17,463,033		17,463,033			31
41	Subprovider - IRF	4,143,664	-219,815	3,923,849			41
43	Nursery	2,204,037		2,204,037			43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	16,541,305		16,541,305			50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	1,570,593		1,570,593			50.02
51	Recovery Room	1,572,321		1,572,321			51
53	Anesthesiology	1,196,092		1,196,092			53
54	Radiology-Diagnostic	6,944,834		6,944,834			54
54.01	BREAST DIAGNOSIS CENTER	1,606,524		1,606,524			54.01
55	Radiology-Therapeutic	2,626,526		2,626,526			55
56	Radioisotope	1,812,057		1,812,057			56
57	CT Scan	2,591,440		2,591,440			57
58	MRI	1,745,812		1,745,812			58
59	Cardiac Catheterization	5,414,642		5,414,642			59
60	Laboratory	15,945,680		15,945,680			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,708,435		4,708,435			65
65.01	SLEEP LAB	650,324		650,324			65.01
66	Physical Therapy	4,789,867		4,789,867			66
66.01	OP PHYSICAL THERAPY	1,839,300		1,839,300			66.01
66.02	OP THERAPY SERVICES	3,628,620		3,628,620			66.02
67	Occupational Therapy	1,897,191		1,897,191			67
68	Speech Pathology	758,113		758,113			68
69	Electrocardiology	3,975,657		3,975,657			69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	326,882		326,882			70
71	Medical Supplies Charged to Patients	15,751,575		15,751,575			71
72	Impl. Dev. Charged to Patients	8,499,190		8,499,190			72
73	Drugs Charged to Patients	26,745,438		26,745,438			73
74	Renal Dialysis	2,237,572		2,237,572			74
75	ASC (Non-Distinct Part)	3,884,366		3,884,366			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	5,901,828		5,901,828			76.01
76.97	CARDIAC REHABILITATION	1,554,123		1,554,123			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,243,015		2,243,015			90
90.01	URGENT CARE CENTER	1,815,054		1,815,054			90.01
91	Emergency	18,638,677		18,638,677			91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	4,730,778		4,730,778			101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	256,042,863	-14,385,592	241,657,271			118
	NONREIMBURSABLE COST CENTERS						

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		24	25	26				
190	Gift, Flower, Coffee Shop & Canteen	749,790		749,790				190
192	Physicians' Private Offices	15,029,903		15,029,903				192
193	Nonpaid Workers	471,202		471,202				193
194	DEVELOPMENT	1,106		1,106				194
194.01	NON ALLOWABLE HOSPICE	733,597		733,597				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 Centers							201
202	TOTAL (sum of lines 118-201)	273,028,461	-14,385,592	258,642,869				202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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		35,749	25,908	61,657	61,657		4
5	Administrative & General	2,677,628	1,354,270	981,469	5,013,367	15,123	5,028,490	5
6	Maintenance & Repairs							6
7	Operation of Plant		1,906,416	1,381,624	3,288,040	1,409	397,407	7
8	Laundry & Linen Service		53,071	38,462	91,533	98	29,024	8
9	Housekeeping		255,501	185,167	440,668	1,433	116,035	9
10	Dietary		90,468	65,564	156,032	272	14,813	10
11	Cafeteria		324,510	235,180	559,690	992	65,189	11
12	Maintenance of Personnel							12
13	Nursing Administration		23,937	17,347	41,284	731	41,455	13
14	Central Services & Supply		474,365	343,783	818,148		20,613	14
15	Pharmacy		89,339	64,746	154,085	1,812	102,052	15
16	Medical Records & Library		69,378	50,280	119,658	594	40,527	16
17	Social Service		6,903	5,003	11,906	301	16,651	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		96,576	69,991	166,567	3,132	137,900	21
22	I&R Services-Other Prgm Costs Apprvd					300	109,371	22
23	Paramed Ed Prgm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,713,216	1,241,605	2,954,821	9,522	615,276	30
31	Intensive Care Unit		472,325	342,304	814,629	4,060	266,555	31
41	Subprovider - IRF		129,479	93,836	223,315	913	57,002	41
43	Nursery		72,432	52,493	124,925	546	34,365	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		854,309	619,136	1,473,445	2,549	238,940	50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER						28,804	50.02
51	Recovery Room		54,777	39,698	94,475	504	23,916	51
53	Anesthesiology		96,334	69,816	166,150		14,358	53
54	Radiology-Diagnostic		522,158	378,419	900,577	1,307	92,680	54
54.01	BREAST DIAGNOSIS CENTER		84,130	60,971	145,101	348	23,462	54.01
55	Radiology-Therapeutic		103,134	74,743	177,877	464	40,925	55
56	Radioisotope		35,611	25,808	61,419	280	29,099	56
57	CT Scan		24,179	17,523	41,702	550	40,498	57
58	MRI		61,588	44,634	106,222	351	26,621	58
59	Cardiac Catheterization		148,495	107,617	256,112	1,040	87,347	59
60	Laboratory		344,344	249,554	593,898		266,429	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		47,885	34,703	82,588	1,262	77,012	65
65.01	SLEEP LAB		11,525	8,352	19,877	172	10,775	65.01
66	Physical Therapy		209,253	151,650	360,903	26	75,022	66
66.01	OP PHYSICAL THERAPY		5,762	4,176	9,938		33,207	66.01
66.02	OP THERAPY SERVICES						66,174	66.02
67	Occupational Therapy		76,397	55,366	131,763		30,078	67
68	Speech Pathology		12,032	8,720	20,752	222	12,793	68
69	Electrocardiology		338,916	245,620	584,536	627	49,706	69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography		12,066	8,745	20,811	68	4,924	70
71	Medical Supplies Charged to Patients						265,445	71
72	Impl. Dev. Charged to Patients						143,422	72
73	Drugs Charged to Patients						378,819	73
74	Renal Dialysis		12,066	8,745	20,811		40,249	74
75	ASC (Non-Distinct Part)		314,576	227,980	542,556	819	50,110	75
76	WOUND CARE							76
76.01	OP ONCOLOGY		42,883	31,078	73,961	1,695	98,820	76.01
76.97	CARDIAC REHABILITATION					491	27,641	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		28,812	20,880	49,692	533	38,167	90
90.01	URGENT CARE CENTER					294	32,606	90.01
91	Emergency		442,188	320,464	762,652	4,380	292,758	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency					1,158	84,806	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	2,677,628	11,051,355	8,009,160	21,738,143	60,378	4,789,848	118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
190	Gift, Flower, Coffee Shop & Canteen		72,363	52,443	124,806	25	9,318	190
192	Physicians' Private Offices		877,727	636,108	1,513,835	1,247	220,391	192
193	Nonpaid Workers		79,301	57,471	136,772	7	3,928	193
194	DEVELOPMENT						20	194
194.01	NON ALLOWABLE HOSPICE		102,903	74,576	177,479		4,985	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 Centers							201
202	TOTAL (sum of lines 118-201)	2,677,628	12,183,649	8,829,758	23,691,035	61,657	5,028,490	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	3,686,856						7
8	Laundry & Linen Service	22,016	142,671					8
9	Housekeeping	105,994		664,130				9
10	Dietary	37,531		7,004	215,652			10
11	Cafeteria	134,623		25,123		785,617		11
12	Maintenance of Personnel							12
13	Nursing Administration	9,930		1,853		9,280	104,533	13
14	Central Services & Supply	196,790		36,724				14
15	Pharmacy	37,062		6,916		24,912		15
16	Medical Records & Library	28,782		5,371		8,311		16
17	Social Service	2,864		534		5,096		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	40,065		7,477		103,953		21
22	I&R Services-Other Prgm Costs Apprvd					6,862		22
23	Paramed Ed Prgm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	710,727	103,639	132,632	156,655	180,950	38,892	30
31	Intensive Care Unit	195,944	24,149	36,566	36,501	65,222	14,018	31
41	Subprovider - IRF	53,714	8,400	10,024	12,697	16,100	3,460	41
43	Nursery	30,048		5,607		8,585	1,845	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	354,410		66,138		50,735	10,904	50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER							50.02
51	Recovery Room	22,724		4,241		6,775	1,456	51
53	Anesthesiology	39,964		7,458				53
54	Radiology-Diagnostic	216,617		40,424		20,106		54
54.01	BREAST DIAGNOSIS CENTER	34,901		6,513		7,223		54.01
55	Radiology-Therapeutic	42,785		7,984		6,292		55
56	Radioisotope	14,773		2,757		3,592		56
57	CT Scan	10,031		1,872		8,468		57
58	MRI	25,550		4,768		4,778		58
59	Cardiac Catheterization	61,603		11,496		15,437		59
60	Laboratory	142,851		26,658				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	19,865		3,707		21,735	4,671	65
65.01	SLEEP LAB	4,781		892		3,061		65.01
66	Physical Therapy	86,808		16,200		760		66
66.01	OP PHYSICAL THERAPY	2,390		446				66.01
66.02	OP THERAPY SERVICES							66.02
67	Occupational Therapy	31,693		5,914				67
68	Speech Pathology	4,991		931		3,046		68
69	Electrocardiology	140,599		26,238		9,892	2,126	69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography	5,006		934		1,465	315	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	5,006		934				74
75	ASC (Non-Distinct Part)	130,502		24,353		11,931	2,564	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	17,790		3,320		31,859	6,847	76.01
76.97	CARDIAC REHABILITATION					7,974		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	11,952		2,230		6,439		90
90.01	URGENT CARE CENTER					6,250		90.01
91	Emergency	183,442		34,233		81,124	17,435	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency					16,701		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	3,217,124	136,188	576,472	205,853	754,914	104,533	118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
190	Gift, Flower, Coffee Shop & Canteen	30,020		5,602		1,680		190
192	Physicians' Private Offices	364,125		67,951		28,781		192
193	Nonpaid Workers	32,898		6,139		242		193
194	DEVELOPMENT							194
194.01	NON ALLOWABLE HOSPICE	42,689	6,483	7,966	9,799			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 Centers							201
202	TOTAL (sum of lines 118-201)	3,686,856	142,671	664,130	215,652	785,617	104,533	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	1,072,275						14
15	Pharmacy	1,825	328,664					15
16	Medical Records & Library			203,243				16
17	Social Service	5			37,357			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					459,094		21
22	I&R Services-Other Prgm Costs Apprvd						116,533	22
23	Paramed Ed Prgm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,888	238	17,432	27,007			30
31	Intensive Care Unit	24,660	304	4,919	6,293			31
41	Subprovider - IRF	1,759	7	955	2,189			41
43	Nursery			954				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	40,178	765	11,988				50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER	3		543				50.02
51	Recovery Room	106	1	1,931				51
53	Anesthesiology	19,629	48	4,547				53
54	Radiology-Diagnostic	92	10	8,679				54
54.01	BREAST DIAGNOSIS CENTER		3	1,498				54.01
55	Radiology-Therapeutic	472	4	2,695				55
56	Radioisotope	22,986	3	3,198				56
57	CT Scan	1,659	109	21,233				57
58	MRI	4,967	1	5,000				58
59	Cardiac Catheterization	3,076	32	7,655				59
60	Laboratory	46,841		20,498				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,481	1,475	8,262				65
65.01	SLEEP LAB	460		738				65.01
66	Physical Therapy	419	1	2,799				66
66.01	OP PHYSICAL THERAPY	295		1,388				66.01
66.02	OP THERAPY SERVICES	600	12	2,784				66.02
67	Occupational Therapy	1,006		1,188				67
68	Speech Pathology			559				68
69	Electrocardiology	815	1	5,926				69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography	366		319				70
71	Medical Supplies Charged to Patients	510,066		6,287				71
72	Impl. Dev. Charged to Patients	275,591		2,455				72
73	Drugs Charged to Patients		323,299	24,491				73
74	Renal Dialysis	827	6	902				74
75	ASC (Non-Distinct Part)	2,785		904				75
76	WOUND CARE							76
76.01	OP ONCOLOGY	2,026	164	3,889				76.01
76.97	CARDIAC REHABILITATION	133		526				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	453	1,766	545				90
90.01	URGENT CARE CENTER	1,574	151	125				90.01
91	Emergency	39,831	194	23,916	1,868			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,818	36	1,515				101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,048,692	328,630	203,243	37,357			118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	22,722	1					192
193	Nonpaid Workers							193
194	DEVELOPMENT							194
194.01	NON ALLOWABLE HOSPICE	861	33					194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments					459,094	116,533	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,072,275	328,664	203,243	37,357	459,094	116,533	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	4,982,679		4,982,679			30
31	Intensive Care Unit	1,493,820		1,493,820			31
41	Subprovider - IRF	390,535		390,535			41
43	Nursery	206,875		206,875			43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,250,052		2,250,052			50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	29,350		29,350			50.02
51	Recovery Room	156,129		156,129			51
53	Anesthesiology	252,154		252,154			53
54	Radiology-Diagnostic	1,280,492		1,280,492			54
54.01	BREAST DIAGNOSIS CENTER	219,049		219,049			54.01
55	Radiology-Therapeutic	279,498		279,498			55
56	Radioisotope	138,107		138,107			56
57	CT Scan	126,122		126,122			57
58	MRI	178,258		178,258			58
59	Cardiac Catheterization	443,798		443,798			59
60	Laboratory	1,097,175		1,097,175			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	225,058		225,058			65
65.01	SLEEP LAB	40,756		40,756			65.01
66	Physical Therapy	542,938		542,938			66
66.01	OP PHYSICAL THERAPY	47,664		47,664			66.01
66.02	OP THERAPY SERVICES	69,570		69,570			66.02
67	Occupational Therapy	201,642		201,642			67
68	Speech Pathology	43,294		43,294			68
69	Electrocardiology	820,466		820,466			69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	34,208		34,208			70
71	Medical Supplies Charged to Patients	781,798		781,798			71
72	Impl. Dev. Charged to Patients	421,468		421,468			72
73	Drugs Charged to Patients	726,609		726,609			73
74	Renal Dialysis	68,735		68,735			74
75	ASC (Non-Distinct Part)	766,524		766,524			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	240,371		240,371			76.01
76.97	CARDIAC REHABILITATION	36,765		36,765			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	111,777		111,777			90
90.01	URGENT CARE CENTER	41,000		41,000			90.01
91	Emergency	1,441,833		1,441,833			91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	108,034		108,034			101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	20,294,603		20,294,603			118
	NONREIMBURSABLE COST CENTERS						

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		24	25	26				
190	Gift, Flower, Coffee Shop & Canteen	171,451		171,451				190
192	Physicians' Private Offices	2,219,053		2,219,053				192
193	Nonpaid Workers	179,986		179,986				193
194	DEVELOPMENT	20		20				194
194.01	NON ALLOWABLE HOSPICE	250,295		250,295				194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS							194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS							194.03
200	Cross Foot Adjustments	575,627		575,627				200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,691,035		23,691,035				202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,057,184						1
2	Cap Rel Costs-Mvble Equip		1,057,184					2
4	Employee Benefits Department	3,102	3,102	105,189,330				4
5	Administrative & General	117,511	117,511	25,779,466	-65,710,093	207,318,368		5
6	Maintenance & Repairs							6
7	Operation of Plant	165,421	165,421	2,405,106		16,384,544	771,150	7
8	Laundry & Linen Service	4,605	4,605	167,924		1,196,628	4,605	8
9	Housekeeping	22,170	22,170	2,444,707		4,783,963	22,170	9
10	Dietary	7,850	7,850	464,584		610,729	7,850	10
11	Cafeteria	28,158	28,158	1,692,847		2,687,639	28,158	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,077	2,077	1,248,158		1,709,144	2,077	13
14	Central Services & Supply	41,161	41,161			849,837	41,161	14
15	Pharmacy	7,752	7,752	3,092,612		4,207,463	7,752	15
16	Medical Records & Library	6,020	6,020	1,013,804		1,670,865	6,020	16
17	Social Service	599	599	514,343		686,494	599	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	8,380	8,380	5,344,985		5,685,424	8,380	21
22	I&R Services-Other Prgm Costs Apprvd			511,618		4,509,223		22
23	Paramed Ed Prgm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	148,657	148,657	16,248,325		25,367,533	148,657	30
31	Intensive Care Unit	40,984	40,984	6,927,743		10,989,711	40,984	31
41	Subprovider - IRF	11,235	11,235	1,557,713		2,350,133	11,235	41
43	Nursery	6,285	6,285	932,256		1,416,838	6,285	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	74,129	74,129	4,349,567		9,851,172	74,129	50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER					1,187,565		50.02
51	Recovery Room	4,753	4,753	860,148		986,033	4,753	51
53	Anesthesiology	8,359	8,359			591,972	8,359	53
54	Radiology-Diagnostic	45,308	45,308	2,230,752		3,821,075	45,308	54
54.01	BREAST DIAGNOSIS CENTER	7,300	7,300	594,109		967,305	7,300	54.01
55	Radiology-Therapeutic	8,949	8,949	791,058		1,687,288	8,949	55
56	Radioisotope	3,090	3,090	477,106		1,199,716	3,090	56
57	CT Scan	2,098	2,098	937,847		1,669,656	2,098	57
58	MRI	5,344	5,344	598,160		1,097,558	5,344	58
59	Cardiac Catheterization	12,885	12,885	1,774,450		3,601,214	12,885	59
60	Laboratory	29,879	29,879			10,984,493	29,879	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,155	4,155	2,153,062		3,175,117	4,155	65
65.01	SLEEP LAB	1,000	1,000	293,180		444,235	1,000	65.01
66	Physical Therapy	18,157	18,157	45,142		3,093,037	18,157	66
66.01	OP PHYSICAL THERAPY	500	500			1,369,079	500	66.01
66.02	OP THERAPY SERVICES					2,728,258		66.02
67	Occupational Therapy	6,629	6,629			1,240,065	6,629	67
68	Speech Pathology	1,044	1,044	379,621		527,419	1,044	68
69	Electrocardiology	29,408	29,408	1,070,206		2,049,316	29,408	69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography	1,047	1,047	116,447		202,994	1,047	70
71	Medical Supplies Charged to Patients					10,943,945		71
72	Impl. Dev. Charged to Patients					5,913,076		72
73	Drugs Charged to Patients					15,618,187		73
74	Renal Dialysis	1,047	1,047			1,659,430	1,047	74
75	ASC (Non-Distinct Part)	27,296	27,296	1,397,224		2,065,954	27,296	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	3,721	3,721	2,893,197		4,074,222	3,721	76.01
76.97	CARDIAC REHABILITATION			838,364		1,139,604		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,500	2,500	909,947		1,573,559	2,500	90
90.01	URGENT CARE CENTER			501,651		1,344,307		90.01
91	Emergency	38,369	38,369	7,473,745		12,070,021	38,369	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			1,976,782		3,496,439		101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	958,934	958,934	103,007,956	-65,710,093	197,479,479	672,900	118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
190	Gift, Flower, Coffee Shop & Canteen	6,279	6,279	41,982		384,150	6,279	190
192	Physicians' Private Offices	76,161	76,161	2,127,572		9,086,408	76,161	192
193	Nonpaid Workers	6,881	6,881	11,820		161,947	6,881	193
194	DEVELOPMENT					840		194
194.01	NON ALLOWABLE HOSPICE	8,929	8,929			205,544	8,929	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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	12,183,649	8,829,758	3,421,834		65,710,093	21,577,674	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.524625	8.352149	0.032530		0.316953	27.981163	203
204	Cost to be allocated (Per Wkst. B, Part II)			61,657		5,028,490	3,686,856	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000586		0.024255	4.780984	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	47,932						8
9	Housekeeping		744,375					9
10	Dietary		7,850	47,932				10
11	Cafeteria		28,158		2,259,905			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,077		26,695	1,399,100		13
14	Central Services & Supply		41,161				23,006,693	14
15	Pharmacy		7,752		71,663		39,162	15
16	Medical Records & Library		6,020		23,908			16
17	Social Service		599		14,660		117	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		8,380		299,032			21
22	I&R Services-Other Prgm Costs Apprvd				19,740			22
23	Paramed Ed Prgm-(specify)							23
23.01	RADIOLOGY PARAMEDICAL							23.01
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,819	148,657	34,819	520,523	520,523	748,567	30
31	Intensive Care Unit	8,113	40,984	8,113	187,616	187,616	529,115	31
41	Subprovider - IRF	2,822	11,235	2,822	46,313	46,313	37,737	41
43	Nursery		6,285		24,695	24,695		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		74,129		145,945	145,945	862,067	50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER						58	50.02
51	Recovery Room		4,753		19,489	19,489	2,273	51
53	Anesthesiology		8,359				421,162	53
54	Radiology-Diagnostic		45,308		57,836		1,981	54
54.01	BREAST DIAGNOSIS CENTER		7,300		20,777			54.01
55	Radiology-Therapeutic		8,949		18,099		10,120	55
56	Radioisotope		3,090		10,334		493,177	56
57	CT Scan		2,098		24,359		35,596	57
58	MRI		5,344		13,743		106,563	58
59	Cardiac Catheterization		12,885		44,407		66,002	59
60	Laboratory		29,879				1,005,013	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		4,155		62,523	62,523	96,145	65
65.01	SLEEP LAB		1,000		8,806		9,862	65.01
66	Physical Therapy		18,157		2,185		8,998	66
66.01	OP PHYSICAL THERAPY		500				6,332	66.01
66.02	OP THERAPY SERVICES						12,865	66.02
67	Occupational Therapy		6,629				21,584	67
68	Speech Pathology		1,044		8,763			68
69	Electrocardiology		29,408		28,456	28,456	17,479	69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography		1,047		4,213	4,213	7,847	70
71	Medical Supplies Charged to Patients						10,943,945	71
72	Impl. Dev. Charged to Patients						5,913,076	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		1,047				17,744	74
75	ASC (Non-Distinct Part)		27,296		34,322	34,322	59,755	75
76	WOUND CARE							76
76.01	OP ONCOLOGY		3,721		91,645	91,645	43,479	76.01
76.97	CARDIAC REHABILITATION				22,937		2,855	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		2,500		18,522		9,723	90
90.01	URGENT CARE CENTER				17,978		33,770	90.01
91	Emergency		38,369		233,360	233,360	854,610	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency				48,043		81,916	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	45,754	646,125	45,754	2,171,587	1,399,100	22,500,695	118
	NONREIMBURSABLE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	
190	Gift, Flower, Coffee Shop & Canteen		6,279		4,832			190
192	Physicians' Private Offices		76,161		82,790		487,529	192
193	Nonpaid Workers		6,881		696			193
194	DEVELOPMENT							194
194.01	NON ALLOWABLE HOSPICE	2,178	8,929	2,178			18,469	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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,704,756	6,920,596	1,096,936	4,589,178	2,382,498	2,653,610	202
203	Unit Cost Multiplier (Wkst. B, Part I)	35.566135	9.297190	22.885254	2.030695	1.702879	0.115341	203
204	Cost to be allocated (Per Wkst. B, Part II)	142,671	664,130	215,652	785,617	104,533	1,072,275	204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.976529	0.892198	4.499124	0.347633	0.074714	0.046607	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	15,877,310						15
16	Medical Records & Library		1,200,491,999					16
17	Social Service			48,162				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	11,496	103,145,386	34,819	184,954	184,954		30
31	Intensive Care Unit	14,687	29,104,637	8,113				31
41	Subprovider - IRF	327	5,653,317	2,822	2,870	2,870		41
43	Nursery		5,646,592					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,938	70,934,816					50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER		3,213,156					50.02
51	Recovery Room	50	11,424,494					51
53	Anesthesiology	2,335	26,906,120					53
54	Radiology-Diagnostic	478	51,356,951					54
54.01	BREAST DIAGNOSIS CENTER	129	8,862,653					54.01
55	Radiology-Therapeutic	181	15,948,524					55
56	Radioisotope	130	18,922,064					56
57	CT Scan	5,257	125,640,582					57
58	MRI	36	29,588,212					58
59	Cardiac Catheterization	1,559	45,293,214					59
60	Laboratory		121,291,431					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	71,234	48,888,126					65
65.01	SLEEP LAB		4,363,951					65.01
66	Physical Therapy	65	16,563,458					66
66.01	OP PHYSICAL THERAPY		8,212,089					66.01
66.02	OP THERAPY SERVICES	573	16,471,635					66.02
67	Occupational Therapy		7,027,004					67
68	Speech Pathology		3,307,845					68
69	Electrocardiology	71	35,066,586					69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography		1,885,287					70
71	Medical Supplies Charged to Patients		37,199,901					71
72	Impl. Dev. Charged to Patients		14,527,478					72
73	Drugs Charged to Patients	15,618,187	142,795,831					73
74	Renal Dialysis	285	5,338,489					74
75	ASC (Non-Distinct Part)		5,347,586					75
76	WOUND CARE							76
76.01	OP ONCOLOGY	7,902	23,010,760					76.01
76.97	CARDIAC REHABILITATION		3,112,106					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	85,327	3,225,229					90
90.01	URGENT CARE CENTER	7,283	737,229					90.01
91	Emergency	9,361	141,514,889	2,408				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,743	8,964,371					101
	SPECIAL PURPOSE COST CENTERS							

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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		
118	SUBTOTALS (sum of lines 1-117)	15,875,634	1,200,491,999	48,162	187,824	187,824		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	59						192
193	Nonpaid Workers							193
194	DEVELOPMENT							194
194.01	NON ALLOWABLE HOSPICE	1,617						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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	5,980,056	2,473,417	956,193	8,407,071	5,978,521		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.376642	0.002060	19.853681	44.760366	31.830442		203
204	Cost to be allocated (Per Wkst. B, Part II)	328,664	203,243	37,357	459,094	116,533		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.020700	0.000169	0.775653	2.444278	0.620437		205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	43,922,521		43,922,521	17,578	43,940,099	30
31	Intensive Care Unit	17,463,033		17,463,033	10,835	17,473,868	31
41	Subprovider - IRF	3,923,849		3,923,849	8,702	3,932,551	41
43	Nursery	2,204,037		2,204,037		2,204,037	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	16,541,305		16,541,305		16,541,305	50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	1,570,593		1,570,593	1,860	1,572,453	50.02
51	Recovery Room	1,572,321		1,572,321		1,572,321	51
53	Anesthesiology	1,196,092		1,196,092		1,196,092	53
54	Radiology-Diagnostic	6,944,834		6,944,834	2,575	6,947,409	54
54.01	BREAST DIAGNOSIS CENTER	1,606,524		1,606,524		1,606,524	54.01
55	Radiology-Therapeutic	2,626,526		2,626,526		2,626,526	55
56	Radioisotope	1,812,057		1,812,057		1,812,057	56
57	CT Scan	2,591,440		2,591,440		2,591,440	57
58	MRI	1,745,812		1,745,812		1,745,812	58
59	Cardiac Catheterization	5,414,642		5,414,642		5,414,642	59
60	Laboratory	15,945,680		15,945,680	47,896	15,993,576	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,708,435		4,708,435		4,708,435	65
65.01	SLEEP LAB	650,324		650,324	10,755	661,079	65.01
66	Physical Therapy	4,789,867		4,789,867		4,789,867	66
66.01	OP PHYSICAL THERAPY	1,839,300		1,839,300		1,839,300	66.01
66.02	OP THERAPY SERVICES	3,628,620		3,628,620		3,628,620	66.02
67	Occupational Therapy	1,897,191		1,897,191		1,897,191	67
68	Speech Pathology	758,113		758,113		758,113	68
69	Electrocardiology	3,975,657		3,975,657	4,954	3,980,611	69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	326,882		326,882		326,882	70
71	Medical Supplies Charged to Patients	15,751,575		15,751,575		15,751,575	71
72	Impl. Dev. Charged to Patients	8,499,190		8,499,190		8,499,190	72
73	Drugs Charged to Patients	26,745,438		26,745,438		26,745,438	73
74	Renal Dialysis	2,237,572		2,237,572		2,237,572	74
75	ASC (Non-Distinct Part)	3,884,366		3,884,366		3,884,366	75
76	WOUND CARE						76
76.01	OP ONCOLOGY	5,901,828		5,901,828		5,901,828	76.01
76.97	CARDIAC REHABILITATION	1,554,123		1,554,123	184	1,554,307	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,243,015		2,243,015		2,243,015	90
90.01	URGENT CARE CENTER	1,815,054		1,815,054		1,815,054	90.01
91	Emergency	18,638,677		18,638,677	403,400	19,042,077	91
92	Observation Beds (Non-Distinct Part)	12,516,602		12,516,602		12,516,602	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	4,730,778		4,730,778		4,730,778	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	254,173,873		254,173,873	508,739	254,682,612	200
201	Less Observation Beds	12,516,602		12,516,602		12,516,602	201
202	Total (line 200 minus line 201)	241,657,271		241,657,271		242,166,010	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 SERVICE COST CENTERS							
30	Adults & Pediatrics	80,501,442		80,501,442				30
31	Intensive Care Unit	29,104,637		29,104,637				31
41	Subprovider - IRF	5,653,317		5,653,317				41
43	Nursery	5,646,592		5,646,592				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	24,245,792	46,689,024	70,934,816	0.233190	0.233190	0.233190	50
50.01	SURGICENTER							50.01
50.02	SURGERY RECOVERY CENTER	3,213,156		3,213,156	0.488801	0.488801	0.489380	50.02
51	Recovery Room	4,079,396	7,345,098	11,424,494	0.137627	0.137627	0.137627	51
53	Anesthesiology	8,310,705	18,595,415	26,906,120	0.044454	0.044454	0.044454	53
54	Radiology-Diagnostic	18,792,826	32,564,125	51,356,951	0.135227	0.135227	0.135277	54
54.01	BREAST DIAGNOSIS CENTER	2,833	8,859,820	8,862,653	0.181269	0.181269	0.181269	54.01
55	Radiology-Therapeutic	833,133	15,115,391	15,948,524	0.164688	0.164688	0.164688	55
56	Radioisotope	3,191,511	15,730,553	18,922,064	0.095764	0.095764	0.095764	56
57	CT Scan	37,431,698	88,208,884	125,640,582	0.020626	0.020626	0.020626	57
58	MRI	7,419,313	22,168,899	29,588,212	0.059004	0.059004	0.059004	58
59	Cardiac Catheterization	23,134,335	22,158,879	45,293,214	0.119546	0.119546	0.119546	59
60	Laboratory	69,793,897	51,497,534	121,291,431	0.131466	0.131466	0.131861	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	42,940,292	5,947,834	48,888,126	0.096310	0.096310	0.096310	65
65.01	SLEEP LAB		4,363,951	4,363,951	0.149022	0.149022	0.151486	65.01
66	Physical Therapy	4,958,104	11,605,354	16,563,458	0.289183	0.289183	0.289183	66
66.01	OP PHYSICAL THERAPY	2,272	8,209,817	8,212,089	0.223975	0.223975	0.223975	66.01
66.02	OP THERAPY SERVICES	525	16,471,110	16,471,635	0.220295	0.220295	0.220295	66.02
67	Occupational Therapy	4,292,924	2,734,080	7,027,004	0.269986	0.269986	0.269986	67
68	Speech Pathology	2,650,498	657,347	3,307,845	0.229186	0.229186	0.229186	68
69	Electrocardiology	14,046,536	21,020,050	35,066,586	0.113375	0.113375	0.113516	69
69.01	EP LAB							69.01
69.02	VASCULAR SERVICES							69.02
70	Electroencephalography	549,286	1,336,001	1,885,287	0.173386	0.173386	0.173386	70
71	Medical Supplies Charged to Patients	20,897,446	16,302,455	37,199,901	0.423431	0.423431	0.423431	71
72	Impl. Dev. Charged to Patients	10,606,135	3,921,343	14,527,478	0.585042	0.585042	0.585042	72
73	Drugs Charged to Patients	63,767,287	79,028,544	142,795,831	0.187298	0.187298	0.187298	73
74	Renal Dialysis	4,486,260	852,229	5,338,489	0.419140	0.419140	0.419140	74
75	ASC (Non-Distinct Part)	131,372	5,216,214	5,347,586	0.726377	0.726377	0.726377	75
76	WOUND CARE							76
76.01	OP ONCOLOGY	940,903	22,069,857	23,010,760	0.256481	0.256481	0.256481	76.01
76.97	CARDIAC REHABILITATION	3,311	3,108,795	3,112,106	0.499380	0.499380	0.499439	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	22,592	3,202,637	3,225,229	0.695459	0.695459	0.695459	90
90.01	URGENT CARE CENTER	4,460	732,769	737,229	2.461995	2.461995	2.461995	90.01
91	Emergency	31,053,216	110,461,673	141,514,889	0.131708	0.131708	0.134559	91
92	Observation Beds (Non-Distinct Part)	6,260,887	16,383,057	22,643,944	0.552757	0.552757	0.552757	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		8,964,371	8,964,371				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	528,968,889	671,523,110	1,200,491,999				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	528,968,889	671,523,110	1,200,491,999				202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	58,088,298		58,088,298		58,088,298	30
31	Intensive Care Unit	17,463,033		17,463,033		17,463,033	31
41	Subprovider - IRF	4,143,664		4,143,664		4,143,664	41
43	Nursery	2,204,037		2,204,037		2,204,037	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	16,541,305		16,541,305		16,541,305	50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	1,570,593		1,570,593		1,570,593	50.02
51	Recovery Room	1,572,321		1,572,321		1,572,321	51
53	Anesthesiology	1,196,092		1,196,092		1,196,092	53
54	Radiology-Diagnostic	6,944,834		6,944,834		6,944,834	54
54.01	BREAST DIAGNOSIS CENTER	1,606,524		1,606,524		1,606,524	54.01
55	Radiology-Therapeutic	2,626,526		2,626,526		2,626,526	55
56	Radioisotope	1,812,057		1,812,057		1,812,057	56
57	CT Scan	2,591,440		2,591,440		2,591,440	57
58	MRI	1,745,812		1,745,812		1,745,812	58
59	Cardiac Catheterization	5,414,642		5,414,642		5,414,642	59
60	Laboratory	15,945,680		15,945,680		15,945,680	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,708,435		4,708,435		4,708,435	65
65.01	SLEEP LAB	650,324		650,324		650,324	65.01
66	Physical Therapy	4,789,867		4,789,867		4,789,867	66
66.01	OP PHYSICAL THERAPY	1,839,300		1,839,300		1,839,300	66.01
66.02	OP THERAPY SERVICES	3,628,620		3,628,620		3,628,620	66.02
67	Occupational Therapy	1,897,191		1,897,191		1,897,191	67
68	Speech Pathology	758,113		758,113		758,113	68
69	Electrocardiology	3,975,657		3,975,657		3,975,657	69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	326,882		326,882		326,882	70
71	Medical Supplies Charged to Patients	15,751,575		15,751,575		15,751,575	71
72	Impl. Dev. Charged to Patients	8,499,190		8,499,190		8,499,190	72
73	Drugs Charged to Patients	26,745,438		26,745,438		26,745,438	73
74	Renal Dialysis	2,237,572		2,237,572		2,237,572	74
75	ASC (Non-Distinct Part)	3,884,366		3,884,366		3,884,366	75
76	WOUND CARE						76
76.01	OP ONCOLOGY	5,901,828		5,901,828		5,901,828	76.01
76.97	CARDIAC REHABILITATION	1,554,123		1,554,123		1,554,123	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,243,015		2,243,015		2,243,015	90
90.01	URGENT CARE CENTER	1,815,054		1,815,054		1,815,054	90.01
91	Emergency	18,638,677		18,638,677		18,638,677	91
92	Observation Beds (Non-Distinct Part)	16,546,693		16,546,693		16,546,693	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	4,730,778		4,730,778		4,730,778	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	272,589,556		272,589,556		272,589,556	200
201	Less Observation Beds	16,546,693		16,546,693		16,546,693	201
202	Total (line 200 minus line 201)	256,042,863		256,042,863		256,042,863	202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	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							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	Clinic							90
90.01	URGENT CARE CENTER							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	16,541,305	2,250,052	14,291,253		50
50.01	SURGICENTER					50.01
50.02	SURGERY RECOVERY CENTER	1,570,593	29,350	1,541,243		50.02
51	Recovery Room	1,572,321	156,129	1,416,192		51
53	Anesthesiology	1,196,092	252,154	943,938		53
54	Radiology-Diagnostic	6,944,834	1,280,492	5,664,342		54
54.01	BREAST DIAGNOSIS CENTER	1,606,524	219,049	1,387,475		54.01
55	Radiology-Therapeutic	2,626,526	279,498	2,347,028		55
56	Radioisotope	1,812,057	138,107	1,673,950		56
57	CT Scan	2,591,440	126,122	2,465,318		57
58	MRI	1,745,812	178,258	1,567,554		58
59	Cardiac Catheterization	5,414,642	443,798	4,970,844		59
60	Laboratory	15,945,680	1,097,175	14,848,505		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	4,708,435	225,058	4,483,377		65
65.01	SLEEP LAB	650,324	40,756	609,568		65.01
66	Physical Therapy	4,789,867	542,938	4,246,929		66
66.01	OP PHYSICAL THERAPY	1,839,300	47,664	1,791,636		66.01
66.02	OP THERAPY SERVICES	3,628,620	69,570	3,559,050		66.02
67	Occupational Therapy	1,897,191	201,642	1,695,549		67
68	Speech Pathology	758,113	43,294	714,819		68
69	Electrocardiology	3,975,657	820,466	3,155,191		69
69.01	EP LAB					69.01
69.02	VASCULAR SERVICES					69.02
70	Electroencephalography	326,882	34,208	292,674		70
71	Medical Supplies Charged to Patients	15,751,575	781,798	14,969,777		71
72	Impl. Dev. Charged to Patients	8,499,190	421,468	8,077,722		72
73	Drugs Charged to Patients	26,745,438	726,609	26,018,829		73
74	Renal Dialysis	2,237,572	68,735	2,168,837		74
75	ASC (Non-Distinct Part)	3,884,366	766,524	3,117,842		75
76	WOUND CARE					76
76.01	OP ONCOLOGY	5,901,828	240,371	5,661,457		76.01
76.97	CARDIAC REHABILITATION	1,554,123	36,765	1,517,358		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	2,243,015	111,777	2,131,238		90
90.01	URGENT CARE CENTER	1,815,054	41,000	1,774,054		90.01
91	Emergency	18,638,677	1,441,833	17,196,844		91
92	Observation Beds (Non-Distinct Part)	16,546,693	1,419,342	15,127,351		92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	4,730,778	108,034	4,622,744		101
113	Interest Expense					113
200	Subtotal	190,690,524	14,640,036	176,050,488		200
201	Less Observation Beds	16,546,693	1,419,342	15,127,351		201
202	Total	174,143,831	13,220,694	160,923,137		202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		16,541,305			50
50.01	SURGICENTER					50.01
50.02	SURGERY RECOVERY CENTER		1,570,593			50.02
51	Recovery Room		1,572,321			51
53	Anesthesiology		1,196,092			53
54	Radiology-Diagnostic		6,944,834			54
54.01	BREAST DIAGNOSIS CENTER		1,606,524			54.01
55	Radiology-Therapeutic		2,626,526			55
56	Radioisotope		1,812,057			56
57	CT Scan		2,591,440			57
58	MRI		1,745,812			58
59	Cardiac Catheterization		5,414,642			59
60	Laboratory		15,945,680			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		4,708,435			65
65.01	SLEEP LAB		650,324			65.01
66	Physical Therapy		4,789,867			66
66.01	OP PHYSICAL THERAPY		1,839,300			66.01
66.02	OP THERAPY SERVICES		3,628,620			66.02
67	Occupational Therapy		1,897,191			67
68	Speech Pathology		758,113			68
69	Electrocardiology		3,975,657			69
69.01	EP LAB					69.01
69.02	VASCULAR SERVICES					69.02
70	Electroencephalography		326,882			70
71	Medical Supplies Charged to Patients		15,751,575			71
72	Impl. Dev. Charged to Patients		8,499,190			72
73	Drugs Charged to Patients		26,745,438			73
74	Renal Dialysis		2,237,572			74
75	ASC (Non-Distinct Part)		3,884,366			75
76	WOUND CARE					76
76.01	OP ONCOLOGY		5,901,828			76.01
76.97	CARDIAC REHABILITATION		1,554,123			76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic		2,243,015			90
90.01	URGENT CARE CENTER		1,815,054			90.01
91	Emergency		18,638,677			91
92	Observation Beds (Non-Distinct Part)		16,546,693	22,643,944	0.730734	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		4,730,778			101
113	Interest Expense					113
200	Subtotal		190,690,524	22,643,944		200
201	Less Observation Beds		16,546,693	22,643,944		201
202	Total		174,143,831			202

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V [XX] PPS
Applicable [XX] Title XVIII, Part A [] TEFRA
Boxes: [] 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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	4,982,679		4,982,679	48,186	103.41	16,582	1,714,745	30
31	Intensive Care Unit	1,493,820		1,493,820	8,113	184.13	3,357	618,124	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	390,535		390,535	2,822	138.39	2,031	281,070	41
42	Subprovider I								42
43	Nursery	206,875		206,875	2,528	81.83			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,073,909		7,073,909	61,649		21,970	2,613,939	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0172

WORKSHEET D PART II

Check [] Title V [XX] Hospital [] SUB (Other) [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] TEFRA
Boxes: [] 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	2,250,052	70,934,816	0.031720	9,743,245	309,056	50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	29,350	3,213,156	0.009134			50.02
51	Recovery Room	156,129	11,424,494	0.013666	1,563,626	21,369	51
53	Anesthesiology	252,154	26,906,120	0.009372	3,085,046	28,913	53
54	Radiology-Diagnostic	1,280,492	51,356,951	0.024933	8,909,896	222,150	54
54.01	BREAST DIAGNOSIS CENTER	219,049	8,862,653	0.024716	2,797	69	54.01
55	Radiology-Therapeutic	279,498	15,948,524	0.017525	519,942	9,112	55
56	Radioisotope	138,107	18,922,064	0.007299	1,611,342	11,761	56
57	CT Scan	126,122	125,640,582	0.001004	17,912,887	17,985	57
58	MRI	178,258	29,588,212	0.006025	3,472,157	20,920	58
59	Cardiac Catheterization	443,798	45,293,214	0.009798	10,411,071	102,008	59
60	Laboratory	1,097,175	121,291,431	0.009046	31,629,616	286,122	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	225,058	48,888,126	0.004604	21,352,755	98,308	65
65.01	SLEEP LAB	40,756	4,363,951	0.009339			65.01
66	Physical Therapy	542,938	16,563,458	0.032779	1,688,161	55,336	66
66.01	OP PHYSICAL THERAPY	47,664	8,212,089	0.005804			66.01
66.02	OP THERAPY SERVICES	69,570	16,471,635	0.004224	520	2	66.02
67	Occupational Therapy	201,642	7,027,004	0.028695	1,246,985	35,782	67
68	Speech Pathology	43,294	3,307,845	0.013088	1,135,393	14,860	68
69	Electrocardiology	820,466	35,066,586	0.023397	6,946,285	162,522	69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	34,208	1,885,287	0.018145	276,154	5,011	70
71	Medical Supplies Charged to Pat	781,798	37,199,901	0.021016	6,606,573	138,844	71
72	Impl. Dev. Charged to Patients	421,468	14,527,478	0.029012	5,561,042	161,337	72
73	Drugs Charged to Patients	726,609	142,795,831	0.005088	27,851,980	141,711	73
74	Renal Dialysis	68,735	5,338,489	0.012875	2,302,858	29,649	74
75	ASC (Non-Distinct Part)	766,524	5,347,586	0.143340	58,916	8,445	75
76	WOUND CARE						76
76.01	OP ONCOLOGY	240,371	23,010,760	0.010446	35,253	368	76.01
76.97	CARDIAC REHABILITATION	36,765	3,112,106	0.011814	1,042	12	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	111,777	3,225,229	0.034657	833	29	90
90.01	URGENT CARE CENTER	41,000	737,229	0.055614	1,613	90	90.01
91	Emergency	1,441,833	141,514,889	0.010189	15,918,342	162,192	91
92	Observation Beds (Non-Distinct	1,419,345	22,643,944	0.062681	3,028,942	189,857	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	14,532,005	1,070,621,640		182,875,272	2,233,820	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**WORKSHEET D
PART III**

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE 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 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	48,186		16,582		30
31	Intensive Care Unit	8,113		3,357		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	2,822		2,031		41
42	Subprovider I					42
43	Nursery	2,528				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	61,649		21,970		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0172

WORKSHEET D PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	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 Pat									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	Clinic									90
90.01	URGENT CARE CENTER									90.01
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0172

**WORKSHEET D
PART IV**

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		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	70,934,816			9,743,245		13,549,163		50
50.01	SURGICENTER								50.01
50.02	SURGERY RECOVERY CENTER	3,213,156							50.02
51	Recovery Room	11,424,494			1,563,626		2,078,827		51
53	Anesthesiology	26,906,120			3,085,046		4,994,803		53
54	Radiology-Diagnostic	51,356,951			8,909,896		6,455,633		54
54.01	BREAST DIAGNOSIS CENTER	8,862,653			2,797		967,941		54.01
55	Radiology-Therapeutic	15,948,524			519,942		6,623,142		55
56	Radioisotope	18,922,064			1,611,342		6,582,593		56
57	CT Scan	125,640,582			17,912,887		22,176,872		57
58	MRI	29,588,212			3,472,157		6,340,331		58
59	Cardiac Catheterization	45,293,214			10,411,071		10,090,199		59
60	Laboratory	121,291,431			31,629,616		9,843,259		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	48,888,126			21,352,755		1,323,641		65
65.01	SLEEP LAB	4,363,951					1,294,314		65.01
66	Physical Therapy	16,563,458			1,688,161		86,594		66
66.01	OP PHYSICAL THERAPY	8,212,089					33,820		66.01
66.02	OP THERAPY SERVICES	16,471,635			520		64,168		66.02
67	Occupational Therapy	7,027,004			1,246,985		105,542		67
68	Speech Pathology	3,307,845			1,135,393		59,356		68
69	Electrocardiology	35,066,586			6,946,285		8,102,596		69
69.01	EP LAB								69.01
69.02	VASCULAR SERVICES								69.02
70	Electroencephalography	1,885,287			276,154		393,315		70
71	Medical Supplies Charged to Pat	37,199,901			6,606,573		3,887,539		71
72	Impl. Dev. Charged to Patients	14,527,478			5,561,042		2,953,461		72
73	Drugs Charged to Patients	142,795,831			27,851,980		35,267,744		73
74	Renal Dialysis	5,338,489			2,302,858		438,598		74
75	ASC (Non-Distinct Part)	5,347,586			58,916		1,539,446		75
76	WOUND CARE								76
76.01	OP ONCOLOGY	23,010,760			35,253		3,898,930		76.01
76.97	CARDIAC REHABILITATION	3,112,106			1,042				76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,225,229			833		81,293		90
90.01	URGENT CARE CENTER	737,229			1,613		23,788		90.01
91	Emergency	141,514,889			15,918,342		15,794,934		91
92	Observation Beds (Non-Distinct	22,643,944			3,028,942		3,443,448		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,070,621,640			182,875,272		168,495,290		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0172

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	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	0.233190	13,549,163			3,159,529			50
50.01	SURGICENTER								50.01
50.02	SURGERY RECOVERY CENTER	0.488801							50.02
51	Recovery Room	0.137627	2,078,827			286,103			51
53	Anesthesiology	0.044454	4,994,803			222,039			53
54	Radiology-Diagnostic	0.135227	6,455,633			872,976			54
54.01	BREAST DIAGNOSIS CENTER	0.181269	967,941			175,458			54.01
55	Radiology-Therapeutic	0.164688	6,623,142			1,090,752			55
56	Radioisotope	0.095764	6,582,593			630,375			56
57	CT Scan	0.020626	22,176,872			457,420			57
58	MRI	0.059004	6,340,331			374,105			58
59	Cardiac Catheterization	0.119546	10,090,199			1,206,243			59
60	Laboratory	0.131466	9,843,259			1,294,054			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.096310	1,323,641			127,480			65
65.01	SLEEP LAB	0.149022	1,294,314			192,881			65.01
66	Physical Therapy	0.289183	86,594			25,042			66
66.01	OP PHYSICAL THERAPY	0.223975	33,820			7,575			66.01
66.02	OP THERAPY SERVICES	0.220295	64,168			14,136			66.02
67	Occupational Therapy	0.269986	105,542			28,495			67
68	Speech Pathology	0.229186	59,356			13,604			68
69	Electrocardiology	0.113375	8,102,596			918,632			69
69.01	EP LAB								69.01
69.02	VASCULAR SERVICES								69.02
70	Electroencephalography	0.173386	393,315			68,195			70
71	Medical Supplies Charged to Pat	0.423431	3,887,539			1,646,105			71
72	Impl. Dev. Charged to Patients	0.585042	2,953,461			1,727,899			72
73	Drugs Charged to Patients	0.187298	35,267,744			6,605,578			73
74	Renal Dialysis	0.419140	438,598			183,834			74
75	ASC (Non-Distinct Part)	0.726377	1,539,446			1,118,218			75
76	WOUND CARE								76
76.01	OP ONCOLOGY	0.256481	3,898,930			1,000,001			76.01
76.97	CARDIAC REHABILITATION	0.499380							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.695459	81,293			56,536			90
90.01	URGENT CARE CENTER	2.461995	23,788			58,566			90.01
91	Emergency	0.131708	15,794,934			2,080,319			91
92	Observation Beds (Non-Distinct	0.552757	3,443,448			1,903,390			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		168,495,290			27,545,540			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		168,495,290			27,545,540			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T172

WORKSHEET D
PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
Boxes: ☐ 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	2,250,052	70,934,816	0.031720	11,154	354	50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	29,350	3,213,156	0.009134			50.02
51	Recovery Room	156,129	11,424,494	0.013666	4,761	65	51
53	Anesthesiology	252,154	26,906,120	0.009372	4,974	47	53
54	Radiology-Diagnostic	1,280,492	51,356,951	0.024933	130,965	3,265	54
54.01	BREAST DIAGNOSIS CENTER	219,049	8,862,653	0.024716			54.01
55	Radiology-Therapeutic	279,498	15,948,524	0.017525	6,320	111	55
56	Radioisotope	138,107	18,922,064	0.007299	4,865	36	56
57	CT Scan	126,122	125,640,582	0.001004	79,692	80	57
58	MRI	178,258	29,588,212	0.006025	50,214	303	58
59	Cardiac Catheterization	443,798	45,293,214	0.009798	100,953	989	59
60	Laboratory	1,097,175	121,291,431	0.009046	641,251	5,801	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	225,058	48,888,126	0.004604	312,647	1,439	65
65.01	SLEEP LAB	40,756	4,363,951	0.009339			65.01
66	Physical Therapy	542,938	16,563,458	0.032779	1,404,405	46,035	66
66.01	OP PHYSICAL THERAPY	47,664	8,212,089	0.005804			66.01
66.02	OP THERAPY SERVICES	69,570	16,471,635	0.004224			66.02
67	Occupational Therapy	201,642	7,027,004	0.028695	1,509,265	43,308	67
68	Speech Pathology	43,294	3,307,845	0.013088	415,450	5,437	68
69	Electrocardiology	820,466	35,066,586	0.023397	40,555	949	69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	34,208	1,885,287	0.018145	1,116	20	70
71	Medical Supplies Charged to Pat	781,798	37,199,901	0.021016	94,766	1,992	71
72	Impl. Dev. Charged to Patients	421,468	14,527,478	0.029012	9,258	269	72
73	Drugs Charged to Patients	726,609	142,795,831	0.005088	660,653	3,361	73
74	Renal Dialysis	68,735	5,338,489	0.012875	138,235	1,780	74
75	ASC (Non-Distinct Part)	766,524	5,347,586	0.143340			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	240,371	23,010,760	0.010446	515	5	76.01
76.97	CARDIAC REHABILITATION	36,765	3,112,106	0.011814			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	111,777	3,225,229	0.034657			90
90.01	URGENT CARE CENTER	41,000	737,229	0.055614			90.01
91	Emergency	1,441,833	141,514,889	0.010189	7,887	80	91
92	Observation Beds (Non-Distinct		22,643,944				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	13,112,660	1,070,621,640		5,629,901	115,726	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T172

WORKSHEET D PART IV

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☐ Title XIX ☒ IRF ☐ NF ☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	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 Pat									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	Clinic									90
90.01	URGENT CARE CENTER									90.01
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T172

WORKSHEET D PART IV

Check [] Title V [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
Boxes: [] Title XIX [XX] IRF [] NF [] Other

		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	70,934,816			11,154				50
50.01	SURGICENTER								50.01
50.02	SURGERY RECOVERY CENTER	3,213,156							50.02
51	Recovery Room	11,424,494			4,761				51
53	Anesthesiology	26,906,120			4,974				53
54	Radiology-Diagnostic	51,356,951			130,965				54
54.01	BREAST DIAGNOSIS CENTER	8,862,653							54.01
55	Radiology-Therapeutic	15,948,524			6,320				55
56	Radioisotope	18,922,064			4,865				56
57	CT Scan	125,640,582			79,692				57
58	MRI	29,588,212			50,214				58
59	Cardiac Catheterization	45,293,214			100,953				59
60	Laboratory	121,291,431			641,251				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	48,888,126			312,647				65
65.01	SLEEP LAB	4,363,951							65.01
66	Physical Therapy	16,563,458			1,404,405				66
66.01	OP PHYSICAL THERAPY	8,212,089							66.01
66.02	OP THERAPY SERVICES	16,471,635							66.02
67	Occupational Therapy	7,027,004			1,509,265				67
68	Speech Pathology	3,307,845			415,450				68
69	Electrocardiology	35,066,586			40,555				69
69.01	EP LAB								69.01
69.02	VASCULAR SERVICES								69.02
70	Electroencephalography	1,885,287			1,116				70
71	Medical Supplies Charged to Pat	37,199,901			94,766				71
72	Impl. Dev. Charged to Patients	14,527,478			9,258				72
73	Drugs Charged to Patients	142,795,831			660,653				73
74	Renal Dialysis	5,338,489			138,235				74
75	ASC (Non-Distinct Part)	5,347,586							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	23,010,760			515				76.01
76.97	CARDIAC REHABILITATION	3,112,106							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3,225,229							90
90.01	URGENT CARE CENTER	737,229							90.01
91	Emergency	141,514,889			7,887				91
92	Observation Beds (Non-Distinct	22,643,944							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,070,621,640			5,629,901				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T172

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [] Title XIX - O/P [XX] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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	0.233190							50
50.01	SURGICENTER								50.01
50.02	SURGERY RECOVERY CENTER	0.488801							50.02
51	Recovery Room	0.137627							51
53	Anesthesiology	0.044454							53
54	Radiology-Diagnostic	0.135227							54
54.01	BREAST DIAGNOSIS CENTER	0.181269							54.01
55	Radiology-Therapeutic	0.164688							55
56	Radioisotope	0.095764							56
57	CT Scan	0.020626							57
58	MRI	0.059004							58
59	Cardiac Catheterization	0.119546							59
60	Laboratory	0.131466							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.096310							65
65.01	SLEEP LAB	0.149022							65.01
66	Physical Therapy	0.289183							66
66.01	OP PHYSICAL THERAPY	0.223975							66.01
66.02	OP THERAPY SERVICES	0.220295							66.02
67	Occupational Therapy	0.269986							67
68	Speech Pathology	0.229186							68
69	Electrocardiology	0.113375							69
69.01	EP LAB								69.01
69.02	VASCULAR SERVICES								69.02
70	Electroencephalography	0.173386							70
71	Medical Supplies Charged to Pat	0.423431							71
72	Impl. Dev. Charged to Patients	0.585042							72
73	Drugs Charged to Patients	0.187298							73
74	Renal Dialysis	0.419140							74
75	ASC (Non-Distinct Part)	0.726377							75
76	WOUND CARE								76
76.01	OP ONCOLOGY	0.256481							76.01
76.97	CARDIAC REHABILITATION	0.499380							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.695459							90
90.01	URGENT CARE CENTER	2.461995							90.01
91	Emergency	0.131708							91
92	Observation Beds (Non-Distinct	0.552757							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 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**WORKSHEET D
PART I**

Check ☐ Title V
Applicable ☐ Title XVIII, Part A
Boxes: ☒ 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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	4,982,679		4,982,679	48,186	103.41	1,747	180,657	30
31	Intensive Care Unit	1,493,820		1,493,820	8,113	184.13	1,747	321,675	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	390,535		390,535	2,822	138.39	25	3,460	41
42	Subprovider I								42
43	Nursery	206,875		206,875	2,528	81.83	407	33,305	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	7,073,909		7,073,909	61,649		3,926	539,097	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0172

WORKSHEET D
PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other)
 Applicable ☐ Title XVIII, Part A ☐ IPF
 Boxes: ☒ 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	2,250,052	70,934,816	0.031720			50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	29,350	3,213,156	0.009134			50.02
51	Recovery Room	156,129	11,424,494	0.013666			51
53	Anesthesiology	252,154	26,906,120	0.009372			53
54	Radiology-Diagnostic	1,280,492	51,356,951	0.024933			54
54.01	BREAST DIAGNOSIS CENTER	219,049	8,862,653	0.024716			54.01
55	Radiology-Therapeutic	279,498	15,948,524	0.017525			55
56	Radioisotope	138,107	18,922,064	0.007299			56
57	CT Scan	126,122	125,640,582	0.001004			57
58	MRI	178,258	29,588,212	0.006025			58
59	Cardiac Catheterization	443,798	45,293,214	0.009798			59
60	Laboratory	1,097,175	121,291,431	0.009046			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	225,058	48,888,126	0.004604			65
65.01	SLEEP LAB	40,756	4,363,951	0.009339			65.01
66	Physical Therapy	542,938	16,563,458	0.032779			66
66.01	OP PHYSICAL THERAPY	47,664	8,212,089	0.005804			66.01
66.02	OP THERAPY SERVICES	69,570	16,471,635	0.004224			66.02
67	Occupational Therapy	201,642	7,027,004	0.028695			67
68	Speech Pathology	43,294	3,307,845	0.013088			68
69	Electrocardiology	820,466	35,066,586	0.023397			69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	34,208	1,885,287	0.018145			70
71	Medical Supplies Charged to Pat	781,798	37,199,901	0.021016			71
72	Impl. Dev. Charged to Patients	421,468	14,527,478	0.029012			72
73	Drugs Charged to Patients	726,609	142,795,831	0.005088			73
74	Renal Dialysis	68,735	5,338,489	0.012875			74
75	ASC (Non-Distinct Part)	766,524	5,347,586	0.143340			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	240,371	23,010,760	0.010446			76.01
76.97	CARDIAC REHABILITATION	36,765	3,112,106	0.011814			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	111,777	3,225,229	0.034657			90
90.01	URGENT CARE CENTER	41,000	737,229	0.055614			90.01
91	Emergency	1,441,833	141,514,889	0.010189			91
92	Observation Beds (Non-Distinct	1,419,342	22,643,944	0.062681			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	14,532,002	1,070,621,640				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE 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 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	48,186		1,747		30
31	Intensive Care Unit	8,113		1,747		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	2,822		25		41
42	Subprovider I					42
43	Nursery	2,528		407		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	61,649		3,926		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0172

WORKSHEET D PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	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 Pat									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	Clinic									90
90.01	URGENT CARE CENTER									90.01
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0172

WORKSHEET D PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

		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								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 Pat								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	Clinic								90
90.01	URGENT CARE CENTER								90.01
91	Emergency								91
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0172

WORKSHEET D PART V

Check ☐ Title V - O/P ☒ Hospital ☐ SUB (Other) ☐ Swing Bed SNF
 Applicable ☐ Title XVIII, Part B ☐ IPF ☐ SNF ☐ Swing Bed NF
 Boxes: ☒ Title XIX - O/P ☐ IRF ☐ NF ☐ ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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								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 Pat								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	Clinic								90
90.01	URGENT CARE CENTER								90.01
91	Emergency								91
92	Observation Beds (Non-Distinct								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 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T172

WORKSHEET D
PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other)
Applicable ☐ Title XVIII, Part A ☐ IPF
Boxes: ☒ 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	2,250,052	70,934,816	0.031720			50
50.01	SURGICENTER						50.01
50.02	SURGERY RECOVERY CENTER	29,350	3,213,156	0.009134			50.02
51	Recovery Room	156,129	11,424,494	0.013666			51
53	Anesthesiology	252,154	26,906,120	0.009372			53
54	Radiology-Diagnostic	1,280,492	51,356,951	0.024933			54
54.01	BREAST DIAGNOSIS CENTER	219,049	8,862,653	0.024716			54.01
55	Radiology-Therapeutic	279,498	15,948,524	0.017525			55
56	Radioisotope	138,107	18,922,064	0.007299			56
57	CT Scan	126,122	125,640,582	0.001004			57
58	MRI	178,258	29,588,212	0.006025			58
59	Cardiac Catheterization	443,798	45,293,214	0.009798			59
60	Laboratory	1,097,175	121,291,431	0.009046			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	225,058	48,888,126	0.004604			65
65.01	SLEEP LAB	40,756	4,363,951	0.009339			65.01
66	Physical Therapy	542,938	16,563,458	0.032779			66
66.01	OP PHYSICAL THERAPY	47,664	8,212,089	0.005804			66.01
66.02	OP THERAPY SERVICES	69,570	16,471,635	0.004224			66.02
67	Occupational Therapy	201,642	7,027,004	0.028695			67
68	Speech Pathology	43,294	3,307,845	0.013088			68
69	Electrocardiology	820,466	35,066,586	0.023397			69
69.01	EP LAB						69.01
69.02	VASCULAR SERVICES						69.02
70	Electroencephalography	34,208	1,885,287	0.018145			70
71	Medical Supplies Charged to Pat	781,798	37,199,901	0.021016			71
72	Impl. Dev. Charged to Patients	421,468	14,527,478	0.029012			72
73	Drugs Charged to Patients	726,609	142,795,831	0.005088			73
74	Renal Dialysis	68,735	5,338,489	0.012875			74
75	ASC (Non-Distinct Part)	766,524	5,347,586	0.143340			75
76	WOUND CARE						76
76.01	OP ONCOLOGY	240,371	23,010,760	0.010446			76.01
76.97	CARDIAC REHABILITATION	36,765	3,112,106	0.011814			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	111,777	3,225,229	0.034657			90
90.01	URGENT CARE CENTER	41,000	737,229	0.055614			90.01
91	Emergency	1,441,833	141,514,889	0.010189			91
92	Observation Beds (Non-Distinct		22,643,944				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	13,112,660	1,070,621,640				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T172

WORKSHEET D PART IV

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☒ Title XIX ☒ IRF ☐ NF ☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	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 Pat									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	Clinic									90
90.01	URGENT CARE CENTER									90.01
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T172

WORKSHEET D PART IV

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☒ Title XIX ☒ IRF ☐ NF ☒ Other

		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								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 Pat								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	Clinic								90
90.01	URGENT CARE CENTER								90.01
91	Emergency								91
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T172

WORKSHEET D
PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [XX] Title XIX - O/P [XX] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges				Program Cost		
			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								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 Pat								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	Clinic								90
90.01	URGENT CARE CENTER								90.01
91	Emergency								91
92	Observation Beds (Non-Distinct								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 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0172****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **Title XIX - I/P** ☐ **IRF** ☐ **NF** ☐ **Other**

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	48,186	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	48,186	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)	34,460	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	16,582	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 XIX only)		15
16	Nursery days (title V or 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)	43,940,099	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 (line 21 minus line 26)	43,940,099	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 minus line 36)	43,940,099	37

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0172****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☐ Title XIX - I/P ☐ IRF ☐ 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)						911.89 38
39	Program general inpatient routine service cost (line 9 x line 38)						15,120,960 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)						15,120,960 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	17,473,868	8,113	2,153.81	3,357	7,230,340	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 (Wkst. D-3, col. 3, line 200)						30,143,680 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						52,494,980 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,332,869	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,233,820	51
52	Total Program excludable cost (sum of lines 50 and 51)					4,566,689	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					47,928,291	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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0172

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					13,726	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					911.89	88
89	Observation bed cost (line 87 x line 88) (see instructions)					12,516,602	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	4,982,679	43,940,099	0.113397	12,516,602	1,419,345	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T172

**WORKSHEET D-1
PART I**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☐ Title XIX - I/P ☒ IRF ☐ NF ☐ Other

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,822	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,822	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)	2,822	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,031	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 XIX only)		15
16	Nursery days (title V or 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)	3,932,551	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 (line 21 minus line 26)	3,932,551	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 minus line 36)	3,932,551	37

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T172

**WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☐ Title XIX - I/P ☒ IRF ☐ 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)	1,393.53	38
39	Program general inpatient routine service cost (line 9 x line 38)	2,830,259	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)	2,830,259	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,296,081	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	4,126,340	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	281,070	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	115,726	51
52	Total Program excludable cost (sum of lines 50 and 51)	396,796	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	3,729,544	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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0172****WORKSHEET D-1****PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☐ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☒ **Title XIX - I/P** ☐ **IRF** ☐ **NF** ☒ **Other**

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	48,186	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	48,186	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)	34,460	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,747	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 XIX only)	2,528	15
16	Nursery days (title V or XIX only)	407	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)	58,088,298	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 (line 21 minus line 26)	58,088,298	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 minus line 36)	58,088,298	37

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0172****WORKSHEET D-1
PART II**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **TEFRA**
Boxes: ☒ **Title XIX - I/P** ☐ **IRF** ☒ **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)						1,205.50
39	Program general inpatient routine service cost (line 9 x line 38)						2,106,009
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						
41	Total Program general inpatient routine service cost (line 39 + line 40)						2,106,009
		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)	2,204,037	2,528	871.85	407	354,843	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	17,463,033	8,113	2,152.48	1,747	3,760,383	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 (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						6,221,235
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						535,637
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						
52	Total Program excludable cost (sum of lines 50 and 51)						535,637
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						
	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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0172

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					13,726	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,205.50	88
89	Observation bed cost (line 87 x line 88) (see instructions)					16,546,693	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	4,982,679	58,088,298	0.085778	16,546,693	1,419,342	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T172****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☐ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☒ **Title XIX - I/P** ☒ **IRF** ☐ **NF** ☒ **Other**

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,822	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,822	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)	2,822	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	25	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 XIX only)		15
16	Nursery days (title V or 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)	4,143,664	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 (line 21 minus line 26)	4,143,664	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 minus line 36)	4,143,664	37

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T172

**WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ Title XIX - I/P ☒ IRF ☒ 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)	1,468.34	38
39	Program general inpatient routine service cost (line 9 x line 38)	36,709	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)	36,709	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	36,709	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	3,460	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	3,460	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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0172

WORKSHEET D-3

Check [] Title V [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/IID [] 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		32,925,343		30
31	Intensive Care Unit		14,162,768		31
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.233190	9,743,245	2,272,027	50
50.01	SURGICENTER				50.01
50.02	SURGERY RECOVERY CENTER	0.489380			50.02
51	Recovery Room	0.137627	1,563,626	215,197	51
53	Anesthesiology	0.044454	3,085,046	137,143	53
54	Radiology-Diagnostic	0.135277	8,909,896	1,205,304	54
54.01	BREAST DIAGNOSIS CENTER	0.181269	2,797	507	54.01
55	Radiology-Therapeutic	0.164688	519,942	85,628	55
56	Radioisotope	0.095764	1,611,342	154,309	56
57	CT Scan	0.020626	17,912,887	369,471	57
58	MRI	0.059004	3,472,157	204,871	58
59	Cardiac Catheterization	0.119546	10,411,071	1,244,602	59
60	Laboratory	0.131861	31,629,616	4,170,713	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.096310	21,352,755	2,056,484	65
65.01	SLEEP LAB	0.151486			65.01
66	Physical Therapy	0.289183	1,688,161	488,187	66
66.01	OP PHYSICAL THERAPY	0.223975			66.01
66.02	OP THERAPY SERVICES	0.220295	520	115	66.02
67	Occupational Therapy	0.269986	1,246,985	336,668	67
68	Speech Pathology	0.229186	1,135,393	260,216	68
69	Electrocardiology	0.113516	6,946,285	788,514	69
69.01	EP LAB				69.01
69.02	VASCULAR SERVICES				69.02
70	Electroencephalography	0.173386	276,154	47,881	70
71	Medical Supplies Charged to Patients	0.423431	6,606,573	2,797,428	71
72	Impl. Dev. Charged to Patients	0.585042	5,561,042	3,253,443	72
73	Drugs Charged to Patients	0.187298	27,851,980	5,216,620	73
74	Renal Dialysis	0.419140	2,302,858	965,220	74
75	ASC (Non-Distinct Part)	0.726377	58,916	42,795	75
76	WOUND CARE				76
76.01	OP ONCOLOGY	0.256481	35,253	9,042	76.01
76.97	CARDIAC REHABILITATION	0.499439	1,042	520	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.695459	833	579	90
90.01	URGENT CARE CENTER	2.461995	1,613	3,971	90.01
91	Emergency	0.134559	15,918,342	2,141,956	91
92	Observation Beds (Non-Distinct Part)	0.552757	3,028,942	1,674,269	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		182,875,272	30,143,680	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		182,875,272		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T172

WORKSHEET D-3

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☐ Title XIX ☒ IRF ☐ NF ☐ ICF/IID ☐ 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		4,087,765		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.233190	11,154	2,601	50
50.01	SURGICENTER				50.01
50.02	SURGERY RECOVERY CENTER	0.489380			50.02
51	Recovery Room	0.137627	4,761	655	51
53	Anesthesiology	0.044454	4,974	221	53
54	Radiology-Diagnostic	0.135277	130,965	17,717	54
54.01	BREAST DIAGNOSIS CENTER	0.181269			54.01
55	Radiology-Therapeutic	0.164688	6,320	1,041	55
56	Radioisotope	0.095764	4,865	466	56
57	CT Scan	0.020626	79,692	1,644	57
58	MRI	0.059004	50,214	2,963	58
59	Cardiac Catheterization	0.119546	100,953	12,069	59
60	Laboratory	0.131861	641,251	84,556	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.096310	312,647	30,111	65
65.01	SLEEP LAB	0.151486			65.01
66	Physical Therapy	0.289183	1,404,405	406,130	66
66.01	OP PHYSICAL THERAPY	0.223975			66.01
66.02	OP THERAPY SERVICES	0.220295			66.02
67	Occupational Therapy	0.269986	1,509,265	407,480	67
68	Speech Pathology	0.229186	415,450	95,215	68
69	Electrocardiology	0.113516	40,555	4,604	69
69.01	EP LAB				69.01
69.02	VASCULAR SERVICES				69.02
70	Electroencephalography	0.173386	1,116	193	70
71	Medical Supplies Charged to Patients	0.423431	94,766	40,127	71
72	Impl. Dev. Charged to Patients	0.585042	9,258	5,416	72
73	Drugs Charged to Patients	0.187298	660,653	123,739	73
74	Renal Dialysis	0.419140	138,235	57,940	74
75	ASC (Non-Distinct Part)	0.726377			75
76	WOUND CARE				76
76.01	OP ONCOLOGY	0.256481	515	132	76.01
76.97	CARDIAC REHABILITATION	0.499439			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.695459			90
90.01	URGENT CARE CENTER	2.461995			90.01
91	Emergency	0.134559	7,887	1,061	91
92	Observation Beds (Non-Distinct Part)	0.552757			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,629,901	1,296,081	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,629,901		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E PART A

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 (see instructions)	29,348,984			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,965,067	2,817,928		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	751,921			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments	11,292,523			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	181.05			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)	130.36			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) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	-8.30			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 line 8 plus lines (8.01 and 8.02) (see instructions)	112.82			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	116.38			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	112.82			12
13	Total allowable FTE count for the prior year	103.93			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	103.02			14
15	Sum of lines 12 through 14 divided by 3	106.59			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	106.59			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.588732			19
20	Prior year resident to bed ratio (see instructions)	0.447530			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.447530			21
22	IME payment adjustment (see instructions)	7,921,947	614,734		22
22.01	IME payment adjustment - Managed Care (see instructions)	2,463,475			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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)	3.56			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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	7,921,947	614,734		29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	2,463,475			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0489			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2273			31
32	Sum of lines 30 and 31	0.2762			32
33	Allowable disproportionate share percentage (see instructions)	0.1200	0.1200		33
34	Disproportionate share adjustment (see instructions)	1,089,422	84,538		34
	Uncompensated Care Adjustment	Prior to October 1 (1.00)	(1.01)	On or after October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	6,766,695,164		8,272,872,447	35
35.01	Factor 3 (see instructions)	0.000371900		0.000381061	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,516,534		3,152,469	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,882,229		794,596	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,676,825			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, 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
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
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 41.01 divided by 7 days)				44

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	48,754,166	3,517,200		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 (see instructions)	54,734,841			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	4,433,439			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	4,481,779			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 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	63,650,059			59
60	Primary payer payments	4,293			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	63,645,766			61
62	Deductibles billed to program beneficiaries	4,020,044			62
63	Coinsurance billed to program beneficiaries	223,295			63
64	Allowable bad debts (see instructions)	1,685,446			64
65	Adjusted reimbursable bad debts (see instructions)	1,095,540			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	956,275			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	60,497,967			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-223,588			70.93
70.94	HRR adjustment amount (see instructions)	-983,881			70.94
70.99	HAC adjustment amount (see instructions)	579,608			70.99
71	Amount due provider (see instructions)	58,710,890			71
71.01	Sequestration adjustment (see instructions)	1,174,218			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	56,931,504			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	605,168			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	2,113,526			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION
EXHIBIT 5

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to October 1		On or After October 1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	29,348,984	29,348,984				29,348,984	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	9,782,995			9,782,995		9,782,995	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	751,921	563,941		187,980		751,921	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)							2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)							2.03
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	11,292,523	8,469,392		2,823,131		11,292,523	4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21	0,447,530	0,447,530		0,447,530			5
6	IME payment adjustment	8,536,681	6,402,511		2,134,170		8,536,681	6
6.01	IME payment adjustment for managed care	2,463,475	1,847,606		615,869		2,463,475	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)	8,536,681	6,402,511		2,134,170		8,536,681	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	2,463,475	1,847,606		615,869		2,463,475	9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.1200	0.1200	0.1200	0.1200	0.1200		10
11	Disproportionate share adjustment	1,173,960	880,470		293,490		1,173,960	11
11.01	Uncompensated care payments	2,676,825	1,882,229		794,596		2,676,825	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	52,271,366	39,078,135		13,193,231		52,271,366	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only	54,734,841	40,925,741		13,809,100		54,734,841	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	4,433,439	3,362,730		1,070,709		4,433,439	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL		44,288,471		14,879,809		59,168,280	19
20	Capital DRG other than outlier	3,186,239	2,389,679		796,560		3,186,239	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	162,124	120,093		42,031		162,124	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage	29.1400	29.1400		29.1400			22
23	Indirect medical education adjustment	928,470	696,352		232,118		928,470	23
24	Allowable disproportionate share percentage	0.0575	0.0575		0.0575			24
25	Disproportionate share adjustment	156,606	156,606				156,606	25
26	Total prospective capital payments	4,433,439	3,362,730		1,070,709		4,433,439	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment	-223,588	-167,691		-55,897		-223,588	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-983,881	-737,911		-245,970		-983,881	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment		433,829		145,779		579,608	32

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0172****WORKSHEET E
PART B**Check applicable box: ☒ **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)				1
2	Medical and other services reimbursed under OPPS (see instructions)	27,545,540			2
3	OPPS payments	24,378,750			3
4	Outlier payment (see instructions)	161,028			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. 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, col. 4, line 69)				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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	24,539,778			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,642,383			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	19,897,395			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	2,181,368			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	22,078,763			30
31	Primary payer payments	845			31
32	Subtotal (line 30 minus line 31)	22,077,918			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)	1,169,485			34
35	Adjusted reimbursable bad debts (see instructions)	760,165			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	676,328			36
37	Subtotal (see instructions)	22,838,083			37
38	MSP-LCC reconciliation amount from PS&R	-92			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	22,838,175			40
40.01	Sequestration adjustment (see instructions)	456,764			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	22,314,218			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	67,193			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see 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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-T172****WORKSHEET E
PART B**Check applicable box: ☐ 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)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.850			5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. 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, col. 4, line 69)				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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 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)	12			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	-12			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)	-12			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	-12			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)	-12			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	-12			40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-12			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see 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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-0172****WORKSHEET E-1****PART I**

Check ☒ Hospital ☐ SUB (Other)
 Applicable ☐ IPF ☐ SNF
 Boxes: ☐ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			56,407,150		22,120,504
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					
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01	08/13/2018	270,240	08/13/2018	193,714
		.02	12/12/2018	254,114		
		.03				
		.04				
		.05				
		.06				
		.07				
		.08				
		.09				
		.10				
		.50				
		.51				
		.52				
		.53				
		.54				
		.55				
		.56				
		.57				
		.58				
		.59				
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		524,354		193,714
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)			56,931,504		22,314,218
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				
		.02				
		.03				
		.04				
		.05				
		.06				
		.07				
		.08				
		.09				
		.10				
		.50				
		.51				
		.52				
		.53				
		.54				
		.55				
		.56				
		.57				
		.58				
		.59				
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		605,168		67,193
		.02				
7	Total Medicare program liability (see instructions)			57,536,672		22,381,411
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-T172

WORKSHEET E-1

PART I

Check ☐ Hospital ☐ SUB (Other)
Applicable ☐ IPF ☐ SNF
Boxes: ☒ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1			1	2	3	4
1	Total interim payments paid to provider			3,958,268		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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	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. E or Wkst. E-3, line and column as appropriate)			3,958,268		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	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) based on the cost report (1)	.01				6.01
		.02		-49,152		-12 6.02
7	Total Medicare program liability (see instructions)			3,909,116		-12 7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T172

WORKSHEET E-3
PART III

Check ☐ Hospital
Applicable ☒ Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	3,435,790		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.012100		2
3	Inpatient Rehabilitation LIP payments (see instructions)	52,568		3
4	Outlier payments	80,414		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 closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)	1.03		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)	1.03		9
10	Average daily census (see instructions)	7.731507		10
11	Teaching Adjustment Factor (see instructions)	0.135533		11
12	Teaching Adjustment (see instructions)	465,663		12
13	Total PPS Payment (see instructions)	4,034,435		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	4,034,435		17
18	Primary payer payments	24,436		18
19	Subtotal (line 17 less line 18)	4,009,999		19
20	Deductibles	14,740		20
21	Subtotal (line 19 minus line 20)	3,995,259		21
22	Coinsurance	6,365		22
23	Subtotal (line 21 minus line 22)	3,988,894		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)			24
25	Adjusted reimbursable bad debts (see instructions)			25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)			26
27	Subtotal (sum of lines 23 and 25)	3,988,894		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	3,988,894		32
32.01	Sequestration adjustment (see instructions)	79,778		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	3,958,268		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	-49,152		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. 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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0172

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☐ PPS
Applicable ☒ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
Boxes: ☐ SNF ☒ 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	6,221,235		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	6,221,235		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	6,221,235		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 cahрге 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)	1.000000	1.000000	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)	3,761,329		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	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	Titles V or XIX (sum of lines 21 and 27)	2,459,906		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	3,761,329		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 Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	2,459,906		40
41	Interim payments	2,459,906		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T172

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☐ PPS
 Applicable ☒ Title XIX ☒ Subprovider IRF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ 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	36,709		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	36,709		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	36,709		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 cahrge 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)	1.000000	1.000000	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)	36,709		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	36,709		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 Wkst. 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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check [] Title V
Applicable [XX] Title XVIII
Box: [] 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) (see instructions)					2
3	Amount of reduction to Direct GME cap under §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))				-8.30	4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)					4.01
4.02	ACA §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)				109.72	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				117.28	6
7	Enter the lesser of line 5 or line 6				109.72	7
		Primary Care	Other	Total		
		1	2	3		
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	60.19	47.98	108.17		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	56.31	44.89	101.20		9
10	Weighted dental and podiatric resident FTE count for the current year		0.00			10
10.01	Unweighted dental and podiatric resident FTE count for the current year					10.01
11	Total weighted FTE count	56.31	44.89			11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	51.06	47.14			12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	46.56	50.77			13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	51.31	47.60			14
15	Adjustment for residents in initial years of new programs	0.00	0.00			15
15.01	Unweighted adjustment for residents in initial years of new programs					15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16
16.01	Unweighted adjustment for residents displaced by program or hospital closure					16.01
17	Adjusted rolling average FTE count	51.31	47.60			17
18	Per resident amount	113,865.45	110,764.06			18
19	Approved amount for resident costs	5,842,436	5,272,369	11,114,805		19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)					20
21	Direct GME FTE unweighted resident count over cap (see instructions)			7.56		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)			11,114,805		25
COMPUTATION OF PROGRAM PATIENT LOAD		Inpatient Part A	Managed Care			
26	Inpatient days (see instructions)	21,970	6,357			26
27	Total inpatient days (see instructions)	45,754	45,754			27
28	Ratio of inpatient days to total inpatient days	0.480177	0.138939			28
29	Program direct GME amount	5,337,074	1,544,280			29
30	Reduction for direct GME payments for Medicare Advantage		218,207			30
31	Net Program direct GME amount			6,663,147		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 Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)					32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			5,338,489		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)			56,621,320		37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)					38
39	Cost of physicians' services in a teaching hospital (see instructions)					39
40	Primary payer payments (see instructions)			28,729		40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			56,592,591		41
Part B Reasonable Cost						
42	Reasonable cost (see instructions)			27,545,540		42
43	Primary payer payments (see instructions)			845		43
44	Total Part B reasonable cost (line 42 minus line 43)			27,544,695		44
45	Total reasonable cost (sum of lines 41 and 44)			84,137,286		45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.672622		46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.327378		47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B						
48	Total program GME payment (line 31)			6,663,147		48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			4,481,779		49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			2,181,368		50

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

Check [] Title V
Applicable [] Title XVIII
Box: [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) (see instructions)			2
3	Amount of reduction to Direct GME cap under §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 §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §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 1	Other 2	Total 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	
10.01	Unweighted dental and podiatric resident FTE count for the current year			10.01
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 through 13 divided by 3)	0.00	0.00	14
15	Adjustment for residents in initial years of new programs	0.00	0.00	15
15.01	Unweighted adjustment for residents in initial years of new programs			15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	16
16.01	Unweighted adjustment for residents displaced by program or hospital closure			16.01
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 §413.79(c)(4)			20
21	Direct 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 (see instructions)	3,756	6,227	26
27	Total inpatient days (see instructions)	45,754	45,754	27
28	Ratio of inpatient days to total inpatient days	0.082091	0.136097	28
29	Program direct GME amount			29
30	Reduction for direct GME payments for Medicare Advantage			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 Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 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 (Wkst. D-4, Pt. III, col 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 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
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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	596,051				1
2	Temporary investments	13,872,159				2
3	Notes receivable					3
4	Accounts receivable	63,936,440				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-12,218,672				6
7	Inventory	8,138,857				7
8	Prepaid expenses	1,351,696				8
9	Other current assets	43,073,754				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	118,750,285				11
	FIXED ASSETS					
12	Land	6,795,500				12
13	Land improvements	2,897,524				13
14	Accumulated depreciation	-2,423,375				14
15	Buildings	277,127,253				15
16	Accumulated depreciation	-71,906,206				16
17	Leasehold improvements	1,075,647				17
18	Accumulated depreciation	-1,030,406				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	76,595,402				23
24	Accumulated depreciation	-53,824,919				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)	235,306,420				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,461,418				34
35	Total other assets (sum of lines 31-34)	8,461,418				35
36	Total assets (sum of lines 11, 30 and 35)	362,518,123				36
	Liabilities and Fund Balances					
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	25,635,205				37
38	Salaries, wages and fees payable	10,034,569				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	625,520				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	26,957,086				44
45	Total current liabilities (sum of lines 37 thru 44)	63,252,380				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	1,751,184				49
50	Total long term liabilities (sum of lines 46 thru 49)	1,751,184				50
51	Total liabilities (sum of lines 45 and 50)	65,003,564				51
	CAPITAL ACCOUNTS					
52	General fund balance	297,514,559				52
53	Specific purpose fund					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
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 thru 58)	297,514,559				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	362,518,123				60

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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		247,832,169			1
2	Net income (loss) (from Worksheet G-3, line 29)		-26,623,752			2
3	Total (sum of line 1 and line 2)		221,208,417			3
4	Additions (credit adjustments) (specify)					4
5						5
6	TRANSFER FROM AFFILIATES	76,486,141				6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		76,486,141			10
11	Subtotal (line 3 plus line 10)		297,694,558			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15	CONTR OF PP AND E	179,999				15
16						16
17						17
18	Total deductions (sum of lines 12-17)		179,999			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		297,514,559			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 (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6	TRANSFER FROM AFFILIATES					6
7						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) (specify)					12
13						13
14						14
15	CONTR OF PP AND E					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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	86,148,034		86,148,034	1
2	Subprovider IPF				2
3	Subprovider IRF	5,653,317		5,653,317	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)	91,801,351		91,801,351	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	29,104,637		29,104,637	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)	29,104,637		29,104,637	16
17	Total inpatient routine care services (sum of lines 10 and 16)	120,905,988		120,905,988	17
18	Ancillary services	399,753,380		399,753,380	18
19	Outpatient services		670,884,326	670,884,326	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		8,964,371	8,964,371	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIANS REVENUE		10,448,129	10,448,129	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	520,659,368	690,296,826	1,210,956,194	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		323,741,662	29
30	Add (specify)			30
31				31
32	COMMUNITY BENEFIT	520,000		32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		520,000	36
37	Deduct (specify)			37
38	ROUNDING	-3		38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-3	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		324,261,659	43

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,210,956,194	1
2	Less contractual allowances and discounts on patients' accounts	921,983,884	2
3	Net patient revenues (line 1 minus line 2)	288,972,310	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	324,261,659	4
5	Net income from service to patients (line 3 minus line 4)	-35,289,349	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	5,975	6
7	Income from investments	412,586	7
8	Revenues from telephone and other miscellaneous communication services	58,523	8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	1,191,990	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	685,123	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	30,970	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen	192,918	20
21	Rental of vending machines	58,473	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.01	Other (FITNESS CENTER REVENUE)	2,908,451	24.01
24.02	Other (MISCELLANEOUS OTHER REVENUE)	209,989	24.02
24.03	Other (HOSPICE RENT)	316,493	24.03
24.04	Other (OTHER REVENUE HOSPICE)	141,132	24.04
24.05	Other (RADIOLOGY REVENUE)		24.05
24.06	Other (RENTAL REVENUE)	2,452,974	24.06
25	Total other income (sum of lines 6-24)	8,665,597	25
26	Total (line 5 plus line 25)	-26,623,752	26
29	Net income (or loss) for the period (line 26 minus line 28)	-26,623,752	29

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	802,721	236,274			117,685	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	942,576	277,441	43,022			6
7	Physical Therapy	287,408	84,597	12,158	404,635		7
8	Occupational Therapy				199,039		8
9	Speech Pathology	12,376	3,643				9
10	Medical Social Services	35,125	10,339	3,750	2,000		10
11	Home Health Aide	55,870	16,445	5,890			11
12	Supplies (see instructions)					83,036	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)	2,136,076	628,739	64,820	605,674	200,721	24

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	1,156,680	-203,896	952,784		952,784	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	1,263,039		1,263,039		1,263,039	6
7	Physical Therapy	788,798		788,798		788,798	7
8	Occupational Therapy	199,039		199,039		199,039	8
9	Speech Pathology	16,019		16,019		16,019	9
10	Medical Social Services	51,214		51,214		51,214	10
11	Home Health Aide	78,205		78,205		78,205	11
12	Supplies (see instructions)	83,036		83,036		83,036	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)	3,636,030	-203,896	3,432,134		3,432,134	24

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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	952,784				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	1,263,039				6
7	Physical Therapy	788,798				7
8	Occupational Therapy	199,039				8
9	Speech Pathology	16,019				9
10	Medical Social Services	51,214				10
11	Home Health Aide	78,205				11
12	Supplies (see instructions)	83,036				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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	3,432,134				24

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		952,784	952,784		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		1,263,039	485,370	1,748,409	6
7	Physical Therapy		788,798	303,126	1,091,924	7
8	Occupational Therapy		199,039	76,488	275,527	8
9	Speech Pathology		16,019	6,156	22,175	9
10	Medical Social Services		51,214	19,681	70,895	10
11	Home Health Aide		78,205	30,053	108,258	11
12	Supplies (see instructions)		83,036	31,910	114,946	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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		3,432,134		3,432,134	24

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-952,784	4,958,700	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care					1,263,039	2,526,078	6
7	Physical Therapy					788,798	1,577,596	7
8	Occupational Therapy					199,039	398,078	8
9	Speech Pathology					16,019	32,038	9
10	Medical Social Services					51,214	102,428	10
11	Home Health Aide					78,205	156,410	11
12	Supplies (see instructions)					83,036	166,072	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 Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					1,526,566	4,958,700	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						952,784	25
26	Unit Cost Multiplier						0.192144	26

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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				20,931	20,931	6,634	1
2	Skilled Nursing Care	1,748,409			30,662	1,779,071	563,882	2
3	Physical Therapy	1,091,924			9,349	1,101,273	349,052	3
4	Occupational Therapy	275,527				275,527	87,329	4
5	Speech Pathology	22,175			403	22,578	7,156	5
6	Medical Social Services	70,895			1,143	72,038	22,833	6
7	Home Health Aide	108,258			1,817	110,075	34,889	7
8	Supplies	114,946				114,946	36,432	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)	3,432,134			64,305	3,496,439	1,108,207	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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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						25,156	1
2	Skilled Nursing Care						53,563	2
3	Physical Therapy						4,183	3
4	Occupational Therapy						2,195	4
5	Speech Pathology						1,462	5
6	Medical Social Services							6
7	Home Health Aide						11,002	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)						97,561	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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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							1
2	Skilled Nursing Care				656	8,384		2
3	Physical Therapy					6,504		3
4	Occupational Therapy					2,055		4
5	Speech Pathology					128		5
6	Medical Social Services					113		6
7	Home Health Aide					472		7
8	Supplies			9,448		811		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)			9,448	656	18,467		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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtlI) 27	TOTAL HHA COSTS 28		
1	Administrative and General	52,721		52,721				1
2	Skilled Nursing Care	2,405,556		2,405,556	27,110	2,432,666		2
3	Physical Therapy	1,461,012		1,461,012	16,466	1,477,478		3
4	Occupational Therapy	367,106		367,106	4,137	371,243		4
5	Speech Pathology	31,324		31,324	353	31,677		5
6	Medical Social Services	94,984		94,984	1,070	96,054		6
7	Home Health Aide	156,438		156,438	1,763	158,201		7
8	Supplies	161,637		161,637	1,822	163,459		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)	4,730,778		4,730,778	52,721	4,730,778		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.				0.011270			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.

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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			643,427		20,931		1
2	Skilled Nursing Care			942,576		1,779,071		2
3	Physical Therapy			287,408		1,101,273		3
4	Occupational Therapy					275,527		4
5	Speech Pathology			12,376		22,578		5
6	Medical Social Services			35,125		72,038		6
7	Home Health Aide			55,870		110,075		7
8	Supplies					114,946		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)			1,976,782		3,496,439		20
21	Total cost to be allocated			64,305		1,108,207		21
22	Unit Cost Multiplier			0.032530		0.316953		22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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					12,388		1
2	Skilled Nursing Care					26,376		2
3	Physical Therapy					2,060		3
4	Occupational Therapy					1,081		4
5	Speech Pathology					720		5
6	Medical Social Services							6
7	Home Health Aide					5,418		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)					48,043		20
21	Total cost to be allocated					97,561		21
22	Unit Cost Multiplier					2.030702		22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	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
2	Skilled Nursing Care			1,743	4,069,614			2
3	Physical Therapy				3,157,208			3
4	Occupational Therapy				997,741			4
5	Speech Pathology				62,007			5
6	Medical Social Services				54,925			6
7	Home Health Aide				229,245			7
8	Supplies		81,916		393,631			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)		81,916	1,743	8,964,371			20
21	Total cost to be allocated		9,448	656	18,467			21
22	Unit Cost Multiplier			0.376363				22
22	Unit Cost Multiplier		0.115338		0.002060			22

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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	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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF PATIENT SERVICE COSTS**HHA CCN: 14-7267****WORKSHEET H-3
PARTS I & II**Check applicable box: ☐ Title V ☒ 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	2,432,666		2,432,666	10,711	227.12	1
2	Physical Therapy	3	1,477,478		1,477,478	7,990	184.92	2
3	Occupational Therapy	4	371,243		371,243	2,525	147.03	3
4	Speech Pathology	5	31,677		31,677	139	227.89	4
5	Medical Social Services	6	96,054		96,054	136	706.28	5
6	Home Health Aide	7	158,201		158,201	1,257	125.86	6
7	Total (sum of lines 1-6)		4,567,319		4,567,319	22,758		7

Limitation Cost Comoputation			Program Visits			
	Patient Services	CBSA No.	Part A	PART B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	16974		6,809		8
9	Physical Therapy	16974		5,040		9
10	Occupational Therapy	16974		1,754		10
11	Speech Pathology	16974		88		11
12	Medical Social Services	16974		110		12
13	Home Health Aide	16974		1,020		13
14	Total (sum of lines 8-13)			14,821		14

Supplies and Drugs Cost 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 Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	163,459		163,459	388,586	0.420651	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	0.289183			col. 2, line 2	1
1.01	OP PHYSICAL THERAPY	66.01	0.223975			col. 2, line 2	1.01
1.02	OP THERAPY SERVICES	66.02	0.220295			col. 2, line 2	1.02
2	Occupational Therapy	67	0.269986			col. 2, line 3	2
3	Speech Pathology	68	0.229186			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.423431			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.187298			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: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7267

WORKSHEET H-3
PARTS I & II

Check applicable box: ☐ Title V ☒ 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			Total Program Cost (sum of cols 9-10)	
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		6,809			1,546,460		1,546,460	1
2	Physical Therapy		5,040			931,997		931,997	2
3	Occupational Therapy		1,754			257,891		257,891	3
4	Speech Pathology		88			20,054		20,054	4
5	Medical Social Services		110			77,691		77,691	5
6	Home Health Aide		1,020			128,377		128,377	6
7	Total (sum of lines 1-6)		14,821			2,962,470		2,962,470	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
		Part B			Part B			
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies			225,065			94,674	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: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7267

**WORKSHEET H-4
PARTS I & II**Check applicable box: ☐ Title V ☒ Title XVIII ☐ Title XIX**PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES**

	Description	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	1	2	3		
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				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 in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		2,758,201	11
12	Total PPS Reimbursement - Full Episodes with Outliers		92,357	12
13	Total PPS Reimbursement - LUPA Episodes		70,245	13
14	Total PPS Reimbursement - PEP Episodes		53,838	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		6,033	15
16	Total PPS Outlier Reimbursement - PSP 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 thru 20 minus line 21)		2,980,674	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		2,980,674	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		2,980,674	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		2,980,674	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		2,980,674	31
31.01	Sequestration adjustment (see instructions)		59,613	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		2,921,061	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 14-7267

WORKSHEET H-5

				Part A		Part B		
	DESCRIPTION			mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider						2,921,061	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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					3.01
			.02					3.02
		Program	.03					3.03
		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
			.99					3.99
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						2,921,061	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					5.01
			.02					5.02
		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)							5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)							6.01
			.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						2,921,061	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: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0172

WORKSHEET L

Check ☐ Title V ☒ Hospital ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ SUB (Other) ☐ Cost Method
 Boxes: ☐ Title XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT	1 URBAN	1.01 RURAL	
1	Capital DRG other than outlier	2,723,580	462,659	1
1.01	Model 4 BPCI Capital DRG other than outlier			1.01
2	Capital DRG outlier payments	162,124		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)	117.62		3
4	Number of interns & residents (see instructions)	106.59		4
5	Indirect medical education percentage (see instructions)	29.14		5
6	Indirect medical education adjustment (see instructions)	928,470		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0489		7
8	Percentage of Medicaid patient days to total days (see instructions)	0.2273		8
9	Sum of lines 7 and 8	0.2762		9
10	Allowable disproportionate share percentage (see instructions)	0.0575		10
11	Disproportionate share adjustment (see instructions)	156,606		11
12	Total prospective capital payments (see instructions)	4,433,439		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

KPMG LLP Compu-Max 2552-10

FRANCISCAN ST. JAMES HEALTH Provider CCN: 14-0172	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 03/29/2019 Run Time: 15:23 Version: 2018.12 (03/07/2019)
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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 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							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	Clinic							90
90.01	URGENT CARE CENTER							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							

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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		
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
193	Nonpaid Workers							193
194	DEVELOPMENT							194
194.01	NON ALLOWABLE HOSPICE							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 Centers							201
202	TOTAL (sum of lines 118-201)							202