

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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: 11/21/2018 Time: 12:55 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 FAIRFIELD MEMORIAL HOSPITAL (14-1311) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, 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		HIT	TITLE XIX	
	TITLE V	PART A	PART B			
	1	2	3	4	5	
1	HOSPITAL	169,656	209,407	1	329,686	1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					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		-1			9
10	HEALTH CLINIC - RHC		160,111			10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	169,656	369,517	1	329,686	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: 303 NW 11TH ST	P.O. Box:		1
2	City: FAIRFIELD	State: IL	ZIP Code: 62837	County: WAYNE

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	FAIRFIELD MEMORIAL HOSPITAL	14-1311	14999	1	04 / 01 / 2001	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	14-5552	14999		03 / 26 / 1985	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTG									11
12	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	14-7612	14999		05 / 01 / 1995	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	14-8500	14999		03 / 13 / 2009	N	O	N	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: 07 / 01 / 2017	To: 06 / 30 / 2018		20
21	Type of control (see instructions)	2			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.	N	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)	N	N		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.	2	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.							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 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

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.	2			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			27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N			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)	N	N	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	N	45
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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
56	Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			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)	N			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)						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.	N			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)				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?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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) 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.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
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.	N	Physical Occupational Speech Respiratory	109

		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.	N		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-L, 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.	2		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums 310,442	Paid Losses 1,320	Self Insurance 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 §1983(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

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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)	Y		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:	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.	N	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			157
158	Subprovider - Other					158
159	SNF	N	N	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)	1		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 / 2017	06 / 30 / 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

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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		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			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.	N		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

Bed Complement		N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/17/2018	Y	10/17/2018	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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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.	N 22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N 23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N 24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y 25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N 26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N 27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N 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.	N 29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N 30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N 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.	N 32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N 33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y 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.	N 35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information			
41	First name: ANNA	Last name: GUETERSLOH	Title: PARTNER 41
42	Employer: KERBER, ECK & BRAECKEL		42
43	Phone number: 618-529-1040	E-mail Address: ANNAG@KEBCPA.COM	43

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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	21	7,665	45,744.00		1,200	219	1,906	1
2	HMO and other (see instructions)									2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		21	7,665	45,744.00		1,200	219	1,906	7
8	Intensive Care Unit	31	4	1,460	4,824.00		110	39	201	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								13
14	Total (see instructions)		25	9,125	50,568.00		1,310	258	2,107	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	30	10,950			1,806		7,846	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,138	552	3,487	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					6,457	8,287	23,984	26
27	Total (sum of lines 14-26)		55							27
28	Observation Bed Days								765	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									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

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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)					434	70	637	1
2	HMO and other (see instructions)								2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		202.86			434	70	637	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		19.97						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		25.74						26
27	Total (sum of lines 14-26)		248.57						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

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA**HHA CCN: 14-7612****WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA

County: WAYNE

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours						1
2	Unduplicated Census Count (see instructions)		146.00		48.00	194.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel				5
6	Direct Nursing Service				6
7	Nursing Supervisor				7
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service				10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide				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).	14999	20

PPS ACTIVITY

		Full Episodes				Total (columns 1 through 4)	
		Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4		
21	Skilled Nursing Visits	1,116	183	58	15	1,372	21
22	Skilled Nursing Visit Charges	116,270	19,800	6,050	1,650	143,770	22
23	Physical Therapy Visits	532	12	9	15	568	23
24	Physical Therapy Visit Charges	57,750	1,320	880	1,650	61,600	24
25	Occupational Therapy Visits	168		8	9	185	25
26	Occupational Therapy Visit Charges	18,040		880	990	19,910	26
27	Speech Pathology Visits	12		1		13	27
28	Speech Pathology Visit Charges	1,380		115		1,495	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits						31
32	Home Health Aide Visit Charges						32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,828	195	76	39	2,138	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	193,440	21,120	7,925	4,290	226,775	35
36	Total Number of Episodes (standard/non-outlier)						36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges	27,008	7,577	1,094	318	35,997	38

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA**WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	30		30	12
13	RUB	111		111	13
14	RUA	38		38	14
15	RVC	165		165	15
16	RVB	284		284	16
17	RVA	781		781	17
18	RHC	30		30	18
19	RHB	107		107	19
20	RHA	149		149	20
21	RMC	14		14	21
22	RMB	13		13	22
23	RMA	14		14	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	3		3	28
29	HE2				29
30	HE1	7		7	30
31	HD2				31
32	HD1				32
33	HC2	17		17	33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	5		5	48
49	CC2				49
50	CC1	9		9	50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1	6		6	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1	7		7	74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA	16		16	199
200	TOTAL	1,806		1,806	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	14999	14999	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	1,282,054			207

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-8500

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

1	Street: 303 NW 11TH STREET	1
2	City: FAIRFIELD State: IL ZIP Code: 62837 County: WAYNE	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

	Grant Award	Date	
	1	2	
4	Community Health Center (Section 330(d), PHS Act)		4
5	Migrant Health Center (Section 329(d), PHS Act)		5
6	Health Services for the Homeless (Section 340(d), PHS		6
7	Appalachian Regional Commission		7
8	Look-alikes		8
9	OTHER		9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0900	1700	0900	1700	0900	1700	0900	1700	0900	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

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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)	0.315994	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,551,739	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?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	3,630,303	5
6	Medicaid charges	17,425,549	6
7	Medicaid cost (line 1 times line 6)	5,506,369	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.	324,327	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 fundnig 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)	324,327	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)	1,447,739		1,447,739	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	457,477		457,477	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	457,477		457,477	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)	2,989,397	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	629,751	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	968,847	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,020,550	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	977,578	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,435,055	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,759,382	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,426,953	1,426,953	134,667	1,561,620	-386,109	1,175,511	1
2	00200	Cap Rel Costs-Mvble Equip		592,208	592,208		592,208		592,208	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		3,263,314	3,263,314		3,263,314		3,263,314	4
5	00500	Administrative & General	1,458,220	2,591,540	4,049,760		4,049,760	-1,113,643	2,936,117	5
6	00600	Maintenance & Repairs	314,336	297,270	611,606		611,606		611,606	6
7	00700	Operation of Plant		631,360	631,360		631,360		631,360	7
8	00800	Laundry & Linen Service		441,042	441,042		441,042		441,042	8
9	00900	Housekeeping	357,399	172,373	529,772		529,772		529,772	9
10	01000	Dietary	369,223	296,585	665,808	-404,049	261,759		261,759	10
11	01100	Cafeteria				404,049	404,049	-182,267	221,782	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	290,355	16,034	306,389		306,389		306,389	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	245,110	189,433	434,543		434,543	-9,653	424,890	16
17	01700	Social Service	57,266	4,061	61,327		61,327		61,327	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,227,954	220,737	1,448,691		1,448,691	-136,175	1,312,516	30
31	03100	Intensive Care Unit	174,705	8,855	183,560		183,560		183,560	31
44	04400	Skilled Nursing Facility	787,032	76,208	863,240		863,240		863,240	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,157,830	256,787	1,414,617		1,414,617	-389,154	1,025,463	50
54	05400	Radiology-Diagnostic	569,028	995,381	1,564,409		1,564,409		1,564,409	54
60	06000	Laboratory	774,073	1,127,505	1,901,578		1,901,578		1,901,578	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	169,673	144,639	314,312	-79,081	235,231		235,231	65
66	06600	Physical Therapy	675,152	19,324	694,476		694,476		694,476	66
69	06900	Electrocardiology				79,081	79,081	-39,661	39,420	69
71	07100	Medical Supplies Charged to Patients	54,329	701,344	755,673	-95,117	660,556		660,556	71
72	07200	Impl. Dev. Charged to Patients				95,117	95,117		95,117	72
73	07300	Drugs Charged to Patients	229,259	1,368,828	1,598,087		1,598,087		1,598,087	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	2,097,729	223,666	2,321,395	67,486	2,388,881	-100,003	2,288,878	88
90	09000	Clinic	379,117	124,787	503,904	-67,486	436,418		436,418	90
90.01	09001	WOUND CARE								90.01
90.02	09002	CLINIC	153,873	85,420	239,293		239,293		239,293	90.02
90.03	09003	URGENT CARE	547,088	11,519	558,607		558,607		558,607	90.03
90.04	09004	CISNE CLINIC	62,116	18,712	80,828		80,828		80,828	90.04
91	09100	Emergency	649,601	1,941,813	2,591,414		2,591,414	-1,273,784	1,317,630	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	276,927	70,071	346,998		346,998		346,998	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		313,194	313,194	-134,667	178,527	-178,527		113
118		SUBTOTALS (sum of lines 1-117)	13,077,395	17,630,963	30,708,358		30,708,358	-3,808,976	26,899,382	118
		NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE								190.01
200		TOTAL (sum of lines 118-199)	13,077,395	17,630,963	30,708,358		30,708,358	-3,808,976	26,899,382	200

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA	A	Cafeteria	11	224,065	179,984	1
500	Total reclassifications				224,065	179,984	500
	Code Letter - A						
1	TO RECLASS EKG	B	Electrocardiology	69	39,420	39,661	1
500	Total reclassifications				39,420	39,661	500
	Code Letter - B						
1	TO RECLASS INTEREST	C	Cap Rel Costs-Bldg & Fixt	1		134,667	1
500	Total reclassifications					134,667	500
	Code Letter - C						
1	TO RECLASS IMPLANTABLE DEVICES	D	Impl. Dev. Charged to Patient	72		95,117	1
500	Total reclassifications					95,117	500
	Code Letter - D						
1	BAHAVIORAL HEALTH	E	Rural Health Clinic	88	66,846	640	1
500	Total reclassifications				66,846	640	500
	Code Letter - E						
	GRAND TOTAL (Increases)				330,331	450,069	

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

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RECLASSIFICATIONS**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA	A	Dietary	10	224,065	179,984		1
500	Total reclassifications				224,065	179,984		500
	Code letter - A							
1	TO RECLASS EKG	B	Respiratory Therapy	65	39,420	39,661		1
500	Total reclassifications				39,420	39,661		500
	Code letter - B							
1	TO RECLASS INTEREST	C	Interest Expense	113		134,667	11	1
500	Total reclassifications					134,667		500
	Code letter - C							
1	TO RECLASS IMPLANTABLE DEVICES	D	Medical Supplies Charged to P	71		95,117		1
500	Total reclassifications					95,117		500
	Code letter - D							
1	BAHAVIORAL HEALTH	E	Clinic	90	66,846	640		1
500	Total reclassifications				66,846	640		500
	Code letter - E							
	GRAND TOTAL (Decreases)				330,331	450,069		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Acquisitions				Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Beginning Balances	Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	449,428					449,428		1
2	Land Improvements	640,428	17,525		17,525		657,953		2
3	Buildings and Fixtures	24,161,924	156,085		156,085		24,318,009		3
4	Building Improvements								4
5	Fixed Equipment	1,498,911	388,167		388,167		1,887,078		5
6	Movable Equipment	9,849,957	319,740		319,740	408,629	9,761,068		6
7	HIT-designated Assets	1,435,870					1,435,870		7
8	Subtotal (sum of lines 1-7)	38,036,518	881,517		881,517	408,629	38,509,406		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	38,036,518	881,517		881,517	408,629	38,509,406		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	1,426,953						1,426,953	1
2	Cap Rel Costs-Mvble Equip	592,208						592,208	2
3	Total (sum of lines 1-2)	2,019,161						2,019,161	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	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	1,426,953		1,426,953	0.706706					1
2	Cap Rel Costs-Mvble Equip	592,208		592,208	0.293294					2
3	Total (sum of lines 1-2)	2,019,161		2,019,161	1.000000					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	1,040,844		134,667				1,175,511	1
2	Cap Rel Costs-Mvble Equip	592,208						592,208	2
3	Total (sum of lines 1-2)	1,633,052		134,667				1,767,719	3

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

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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)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)	B	-178,527	Interest Expense	113		3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-2,617	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,838,774				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-359	Administrative & General	5		11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-182,267	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-9,653	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						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			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		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	A	-169,440	Cap Rel Costs-Bldg & Fixt	1	9	32
33	VERIZON RENTAL	B	-92,508	Cap Rel Costs-Bldg & Fixt	1	9	33
33.01	RINARD & WEBER CLINIC	A	-11,661	Cap Rel Costs-Bldg & Fixt	1	9	33.01
33.02	RECRUITING	A	-155,194	Administrative & General	5		33.02
33.03	ADVERTISING	A	-219,207	Administrative & General	5		33.03
33.04	OTHER REVENUE	B	-43,692	Administrative & General	5		33.04
33.05	WAYFAIR RENTAL	B	-112,500	Cap Rel Costs-Bldg & Fixt	1	9	33.05
33.06	PROVIDER TAX	A	-682,783	Administrative & General	5		33.06
34	HOSPITALIST IN RHC	A	-100,003	Rural Health Clinic	88		34
35							35
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43	LOBBING PORTION OF DUES	A	-9,791	Administrative & General	5		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)		-3,808,976				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.

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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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	54	Radiology-Diagnostic	MRI	248,595	248,595			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			248,595	248,595			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	G	DSSI	15.00	DSSI	15.00	MRI	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:

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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	30	Adults & Pediatrics AGGREGATE	104,477	104,477						1
2	30	Adults & Pediatrics								2
3	30	Adults & Pediatrics AGGREGATE	31,698	31,698						3
4	30	Adults & Pediatrics								4
5	30	Adults & Pediatrics								5
6	50	Operating Room AGGREGATE	389,154	389,154						6
7	50	Operating Room								7
8	50	Operating Room								8
9	60	Laboratory								9
10	69	Electrocardiology AGGREGATE	32,771	32,771						10
11	69	Electrocardiology								11
12	69	Electrocardiology AGGREGATE	6,890	6,890						12
13	91	Emergency AGGREGATE	1,750,184	1,273,784	476,400					13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,315,174	1,838,774	476,400					200

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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	30	Adults & Pediatrics AGGREGATE							104,477	1
2	30	Adults & Pediatrics								2
3	30	Adults & Pediatrics AGGREGATE							31,698	3
4	30	Adults & Pediatrics								4
5	30	Adults & Pediatrics								5
6	50	Operating Room AGGREGATE							389,154	6
7	50	Operating Room								7
8	50	Operating Room								8
9	60	Laboratory								9
10	69	Electrocardiology AGGREGATE							32,771	10
11	69	Electrocardiology								11
12	69	Electrocardiology AGGREGATE							6,890	12
13	91	Emergency AGGREGATE							1,273,784	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,838,774	200

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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	1,175,511	1,175,511					1
2	Cap Rel Costs-Mvble Equip	592,208		592,208				2
4	Employee Benefits Department	3,263,314			3,263,314			4
5	Administrative & General	2,936,117	221,954	111,819	363,883	3,633,773	3,633,773	5
6	Maintenance & Repairs	611,606	31,950	16,096	78,439	738,091	115,279	6
7	Operation of Plant	631,360	20,882	10,520		662,762	103,514	7
8	Laundry & Linen Service	441,042	14,429	7,269		462,740	72,274	8
9	Housekeeping	529,772	1,997	1,006	89,185	621,960	97,141	9
10	Dietary	261,759	1,478	745	36,223	300,205	46,888	10
11	Cafeteria	221,782	43,423	21,876	55,913	342,994	53,571	11
12	Maintenance of Personnel							12
13	Nursing Administration	306,389	1,444	727	72,455	381,015	59,509	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	424,890	16,618	8,372	61,165	511,045	79,818	16
17	Social Service	61,327	1,805	909	14,290	78,331	12,234	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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,312,516	164,700	82,974	306,422	1,866,612	291,539	30
31	Intensive Care Unit	183,560	15,038	7,576	43,596	249,770	39,011	31
44	Skilled Nursing Facility	863,240	96,492	48,611	196,395	1,204,738	188,163	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,025,463	73,240	36,898	288,924	1,424,525	222,491	50
54	Radiology-Diagnostic	1,564,409	51,647	26,019	141,995	1,784,070	278,647	54
60	Laboratory	1,901,578	25,587	12,890	193,161	2,133,216	333,178	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	235,231	18,998	9,571	32,503	296,303	46,278	65
66	Physical Therapy	694,476	42,182	21,251	168,477	926,386	144,689	66
69	Electrocardiology	39,420			9,837	49,257	7,693	69
71	Medical Supplies Charged to Patients	660,556	20,036	10,094	13,557	704,243	109,993	71
72	Impl. Dev. Charged to Patients	95,117				95,117	14,856	72
73	Drugs Charged to Patients	1,598,087	30,776	15,505	57,209	1,701,577	265,763	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,288,878	168,446	84,861	540,139	3,082,324	481,427	88
90	Clinic	436,418	19,574	9,861	77,924	543,777	84,930	90
90.01	WOUND CARE							90.01
90.02	CLINIC	239,293	12,241	6,167	38,397	296,098	46,246	90.02
90.03	URGENT CARE	558,607	24,481	12,333	136,520	731,941	114,319	90.03
90.04	CISNE CLINIC	80,828	8,236	4,149	15,500	108,713	16,979	90.04
91	Emergency	1,317,630	26,196	13,197	162,101	1,519,124	237,266	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	346,998	21,661	10,912	69,104	448,675	70,077	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	26,899,382	1,175,511	592,208	3,263,314	26,899,382	3,633,773	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,899,382	1,175,511	592,208	3,263,314	26,899,382	3,633,773	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	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	853,370						6
7	Operation of Plant	19,510	785,786					7
8	Laundry & Linen Service	13,481	12,704	561,199				8
9	Housekeeping	1,866	1,758	111,945	834,670			9
10	Dietary	1,381	1,301	505	1,408	351,688		10
11	Cafeteria	40,570	38,231		41,371		516,737	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,349	1,271		1,376		12,802	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	15,526	14,631		15,833		21,442	16
17	Social Service	1,686	1,589		1,720		4,342	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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	153,881	145,009	102,262	156,918	77,164	77,453	30
31	Intensive Care Unit	14,050	13,240	2,133	14,328	13,117	11,150	31
44	Skilled Nursing Facility	90,153	84,955	95,873	91,933	261,407	57,334	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	68,429	64,484	58,687	69,780		38,210	50
54	Radiology-Diagnostic	48,254	45,472	40,604	49,207		30,503	54
60	Laboratory	23,906	22,528	9,980	24,378		53,324	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	17,750	16,727	10,665	18,101		11,406	65
66	Physical Therapy	39,411	37,139	15,265	40,189		27,653	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	18,720	17,641		19,089		5,736	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	28,755	27,097		29,322		9,658	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	157,382	148,310	1,619	160,487		73,917	88
90	Clinic	18,288	17,233		18,649		13,467	90
90.01	WOUND CARE							90.01
90.02	CLINIC	11,436	10,777		11,662		9,664	90.02
90.03	URGENT CARE	22,873	21,554	533	23,324		21,268	90.03
90.04	CISNE CLINIC							90.04
91	Emergency	24,475	23,064	111,128	24,958		37,408	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	20,238	19,071		20,637			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	853,370	785,786	561,199	834,670	351,688	516,737	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	853,370	785,786	561,199	834,670	351,688	516,737	202

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

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		13	16	17	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	457,322						13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		658,295					16
17	Social Service			99,902				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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	155,243	41,351	59,059	3,126,491		3,126,491	30
31	Intensive Care Unit	18,420	2,765		377,984		377,984	31
44	Skilled Nursing Facility	124,399	9,980	40,843	2,249,778		2,249,778	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	81,223	117,371		2,145,200		2,145,200	50
54	Radiology-Diagnostic		143,582		2,420,339		2,420,339	54
60	Laboratory		99,763		2,700,273		2,700,273	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		37,899		455,129		455,129	65
66	Physical Therapy		25,379		1,256,111		1,256,111	66
69	Electrocardiology		9,929		66,879		66,879	69
71	Medical Supplies Charged to Patients		39,818		915,240		915,240	71
72	Impl. Dev. Charged to Patients				109,973		109,973	72
73	Drugs Charged to Patients		52,128		2,114,300		2,114,300	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		28,511		4,133,977		4,133,977	88
90	Clinic		9,941		706,285		706,285	90
90.01	WOUND CARE							90.01
90.02	CLINIC		2,831		388,714		388,714	90.02
90.03	URGENT CARE		9,190		945,002		945,002	90.03
90.04	CISNE CLINIC				125,692		125,692	90.04
91	Emergency	78,037	27,857		2,083,317		2,083,317	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency				578,698		578,698	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	457,322	658,295	99,902	26,899,382		26,899,382	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	457,322	658,295	99,902	26,899,382		26,899,382	202

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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	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		0	1	2	2A	5	6	
	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		221,954	111,819	333,773	333,773		5
6	Maintenance & Repairs		31,950	16,096	48,046	10,589	58,635	6
7	Operation of Plant		20,882	10,520	31,402	9,508	1,341	7
8	Laundry & Linen Service		14,429	7,269	21,698	6,638	926	8
9	Housekeeping		1,997	1,006	3,003	8,923	128	9
10	Dietary		1,478	745	2,223	4,307	95	10
11	Cafeteria		43,423	21,876	65,299	4,921	2,788	11
12	Maintenance of Personnel							12
13	Nursing Administration		1,444	727	2,171	5,466	93	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		16,618	8,372	24,990	7,331	1,067	16
17	Social Service		1,805	909	2,714	1,124	116	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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		164,700	82,974	247,674	26,778	10,573	30
31	Intensive Care Unit		15,038	7,576	22,614	3,583	965	31
44	Skilled Nursing Facility		96,492	48,611	145,103	17,283	6,194	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		73,240	36,898	110,138	20,436	4,702	50
54	Radiology-Diagnostic		51,647	26,019	77,666	25,594	3,316	54
60	Laboratory		25,587	12,890	38,477	30,603	1,643	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,998	9,571	28,569	4,251	1,220	65
66	Physical Therapy		42,182	21,251	63,433	13,290	2,708	66
69	Electrocardiology					707		69
71	Medical Supplies Charged to Patients		20,036	10,094	30,130	10,103	1,286	71
72	Impl. Dev. Charged to Patients					1,365		72
73	Drugs Charged to Patients		30,776	15,505	46,281	24,411	1,976	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		168,446	84,861	253,307	44,223	10,810	88
90	Clinic		19,574	9,861	29,435	7,801	1,257	90
90.01	WOUND CARE							90.01
90.02	CLINIC		12,241	6,167	18,408	4,248	786	90.02
90.03	URGENT CARE		24,481	12,333	36,814	10,500	1,572	90.03
90.04	CISNE CLINIC		8,236	4,149	12,385	1,560		90.04
91	Emergency		26,196	13,197	39,393	21,793	1,682	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		21,661	10,912	32,573	6,437	1,391	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,175,511	592,208	1,767,719	333,773	58,635	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,175,511	592,208	1,767,719	333,773	58,635	202

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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	42,251						7
8	Laundry & Linen Service	683	29,945					8
9	Housekeeping	95	5,972	18,121				9
10	Dietary	70	27	31	6,753			10
11	Cafeteria	2,056		898		75,962		11
12	Maintenance of Personnel							12
13	Nursing Administration	68		30		1,882	9,710	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	787		344		3,152		16
17	Social Service	85		37		638		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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,797	5,457	3,407	1,482	11,385	3,296	30
31	Intensive Care Unit	712	114	311	252	1,639	391	31
44	Skilled Nursing Facility	4,568	5,116	1,996	5,019	8,428	2,641	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,467	3,131	1,515		5,617	1,725	50
54	Radiology-Diagnostic	2,445	2,167	1,068		4,484		54
60	Laboratory	1,211	533	529		7,839		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	899	569	393		1,677		65
66	Physical Therapy	1,997	815	873		4,065		66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	949		414		843		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	1,457		637		1,420		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	7,975	86	3,484		10,866		88
90	Clinic	927		405		1,980		90
90.01	WOUND CARE							90.01
90.02	CLINIC	579		253		1,421		90.02
90.03	URGENT CARE	1,159	28	506		3,127		90.03
90.04	CISNE CLINIC							90.04
91	Emergency	1,240	5,930	542		5,499	1,657	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,025		448				101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	42,251	29,945	18,121	6,753	75,962	9,710	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,251	29,945	18,121	6,753	75,962	9,710	202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	17	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	37,671						16
17	Social Service		4,714					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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,364	2,787	323,000		323,000		30
31	Intensive Care Unit	158		30,739		30,739		31
44	Skilled Nursing Facility	571	1,927	198,846		198,846		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,710		157,441		157,441		50
54	Radiology-Diagnostic	8,245		124,985		124,985		54
60	Laboratory	5,703		86,538		86,538		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,167		39,745		39,745		65
66	Physical Therapy	1,451		88,632		88,632		66
69	Electrocardiology	568		1,275		1,275		69
71	Medical Supplies Charged to Patients	2,276		46,001		46,001		71
72	Impl. Dev. Charged to Patients			1,365		1,365		72
73	Drugs Charged to Patients	2,980		79,162		79,162		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,630		332,381		332,381		88
90	Clinic	568		42,373		42,373		90
90.01	WOUND CARE							90.01
90.02	CLINIC	162		25,857		25,857		90.02
90.03	URGENT CARE	525		54,231		54,231		90.03
90.04	CISNE CLINIC			13,945		13,945		90.04
91	Emergency	1,593		79,329		79,329		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			41,874		41,874		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	37,671	4,714	1,767,719		1,767,719		118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	37,671	4,714	1,767,719		1,767,719		202

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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	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	104,197						1
2	Cap Rel Costs-Mvble Equip		104,197					2
4	Employee Benefits Department			13,077,395				4
5	Administrative & General	19,674	19,674	1,458,220	-3,633,773	23,265,609		5
6	Maintenance & Repairs	2,832	2,832	314,336		738,091	80,961	6
7	Operation of Plant	1,851	1,851			662,762	1,851	7
8	Laundry & Linen Service	1,279	1,279			462,740	1,279	8
9	Housekeeping	177	177	357,399		621,960	177	9
10	Dietary	131	131	145,158		300,205	131	10
11	Cafeteria	3,849	3,849	224,065		342,994	3,849	11
12	Maintenance of Personnel							12
13	Nursing Administration	128	128	290,355		381,015	128	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,473	1,473	245,110		511,045	1,473	16
17	Social Service	160	160	57,266		78,331	160	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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,599	14,599	1,227,954		1,866,612	14,599	30
31	Intensive Care Unit	1,333	1,333	174,705		249,770	1,333	31
44	Skilled Nursing Facility	8,553	8,553	787,032		1,204,738	8,553	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,492	6,492	1,157,830		1,424,525	6,492	50
54	Radiology-Diagnostic	4,578	4,578	569,028		1,784,070	4,578	54
60	Laboratory	2,268	2,268	774,073		2,133,216	2,268	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,684	1,684	130,253		296,303	1,684	65
66	Physical Therapy	3,739	3,739	675,152		926,386	3,739	66
69	Electrocardiology			39,420		49,257		69
71	Medical Supplies Charged to Patients	1,776	1,776	54,329		704,243	1,776	71
72	Impl. Dev. Charged to Patients					95,117		72
73	Drugs Charged to Patients	2,728	2,728	229,259		1,701,577	2,728	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	14,931	14,931	2,164,575		3,082,324	14,931	88
90	Clinic	1,735	1,735	312,271		543,777	1,735	90
90.01	WOUND CARE							90.01
90.02	CLINIC	1,085	1,085	153,873		296,098	1,085	90.02
90.03	URGENT CARE	2,170	2,170	547,088		731,941	2,170	90.03
90.04	CISNE CLINIC	730	730	62,116		108,713		90.04
91	Emergency	2,322	2,322	649,601		1,519,124	2,322	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,920	1,920	276,927		448,675	1,920	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	104,197	104,197	13,077,395	-3,633,773	23,265,609	80,961	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,175,511	592,208	3,263,314		3,633,773	853,370	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.281620	5.683542	0.249539		0.156186	10.540507	203
204	Cost to be allocated (Per Wkst. B, Part II)					333,773	58,635	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.014346	0.724238	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

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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERV ED	CAFETERIA FTE'S SERV ED	NURSING ADMINIS- TRATION DIRECT NRS ING HRS	
		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	79,110						7
8	Laundry & Linen Service	1,279	58,934					8
9	Housekeeping	177	11,756	77,654				9
10	Dietary	131	53	131	55,394			10
11	Cafeteria	3,849		3,849		374,306		11
12	Maintenance of Personnel							12
13	Nursing Administration	128		128		9,273	149,116	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,473		1,473		15,532		16
17	Social Service	160		160		3,145		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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,599	10,739	14,599	12,154	56,104	50,619	30
31	Intensive Care Unit	1,333	224	1,333	2,066	8,077	6,006	31
44	Skilled Nursing Facility	8,553	10,068	8,553	41,174	41,531	40,562	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,492	6,163	6,492		27,678	26,484	50
54	Radiology-Diagnostic	4,578	4,264	4,578		22,095		54
60	Laboratory	2,268	1,048	2,268		38,626		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,684	1,120	1,684		8,262		65
66	Physical Therapy	3,739	1,603	3,739		20,031		66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	1,776		1,776		4,155		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	2,728		2,728		6,996		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	14,931	170	14,931		53,543		88
90	Clinic	1,735		1,735		9,755		90
90.01	WOUND CARE							90.01
90.02	CLINIC	1,085		1,085		7,000		90.02
90.03	URGENT CARE	2,170	56	2,170		15,406		90.03
90.04	CISNE CLINIC							90.04
91	Emergency	2,322	11,670	2,322		27,097	25,445	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,920		1,920				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	79,110	58,934	77,654	55,394	374,306	149,116	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	785,786	561,199	834,670	351,688	516,737	457,322	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.932828	9.522500	10.748577	6.348846	1.380520	3.066888	203
204	Cost to be allocated (Per Wkst. B, Part II)	42,251	29,945	18,121	6,753	75,962	9,710	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.534079	0.508111	0.233356	0.121909	0.202941	0.065117	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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE ASSIGNED TIME					
		16	17					

	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	84,565,028						16
17	Social Service		3,148					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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,312,251	1,861					30
31	Intensive Care Unit	355,203						31
44	Skilled Nursing Facility	1,282,054	1,287					44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,078,527						50
54	Radiology-Diagnostic	18,440,602						54
60	Laboratory	12,816,450						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,868,858						65
66	Physical Therapy	3,260,407						66
69	Electrocardiology	1,275,518						69
71	Medical Supplies Charged to Patients	5,115,393						71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	6,696,771						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,662,815						88
90	Clinic	1,277,099						90
90.01	WOUND CARE							90.01
90.02	CLINIC	363,709						90.02
90.03	URGENT CARE	1,180,673						90.03
90.04	CISNE CLINIC							90.04
91	Emergency	3,578,698						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	84,565,028	3,148					118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	658,295	99,902					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.007784	31.735070					203
204	Cost to be allocated (Per Wkst. B, Part II)	37,671	4,714					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000445	1.497459					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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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	3,126,491		3,126,491		3,126,491	30
31	Intensive Care Unit	377,984		377,984		377,984	31
44	Skilled Nursing Facility	2,249,778		2,249,778		2,249,778	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,145,200		2,145,200		2,145,200	50
54	Radiology-Diagnostic	2,420,339		2,420,339		2,420,339	54
60	Laboratory	2,700,273		2,700,273		2,700,273	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	455,129		455,129		455,129	65
66	Physical Therapy	1,256,111		1,256,111		1,256,111	66
69	Electrocardiology	66,879		66,879		66,879	69
71	Medical Supplies Charged to Patients	915,240		915,240		915,240	71
72	Impl. Dev. Charged to Patients	109,973		109,973		109,973	72
73	Drugs Charged to Patients	2,114,300		2,114,300		2,114,300	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	4,133,977		4,133,977		4,133,977	88
90	Clinic	706,285		706,285		706,285	90
90.01	WOUND CARE						90.01
90.02	CLINIC	388,714		388,714		388,714	90.02
90.03	URGENT CARE	945,002		945,002		945,002	90.03
90.04	CISNE CLINIC	125,692		125,692		125,692	90.04
91	Emergency	2,083,317		2,083,317		2,083,317	91
92	Observation Beds (Non-Distinct Part)	895,455		895,455		895,455	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	578,698		578,698		578,698	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	27,794,837		27,794,837		27,794,837	200
201	Less Observation Beds	895,455		895,455		895,455	201
202	Total (line 200 minus line 201)	26,899,382		26,899,382		26,899,382	202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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	4,245,583		4,245,583				30
31	Intensive Care Unit	355,203		355,203				31
44	Skilled Nursing Facility	1,282,054		1,282,054				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,993,957	13,084,570	15,078,527	0.142269	0.142269	0.142269	50
54	Radiology-Diagnostic	906,933	17,533,669	18,440,602	0.131251	0.131251	0.131251	54
60	Laboratory	1,188,211	11,628,239	12,816,450	0.210688	0.210688	0.210688	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,077,049	2,543,153	5,620,202	0.080981	0.080981	0.080981	65
66	Physical Therapy	1,209,294	2,051,113	3,260,407	0.385262	0.385262	0.385262	66
69	Electrocardiology	188,865	1,086,653	1,275,518	0.052433	0.052433	0.052433	69
71	Medical Supplies Charged to Patients	1,219,725	3,005,492	4,225,217	0.216614	0.216614	0.216614	71
72	Impl. Dev. Charged to Patients	7,022	131,810	138,832	0.792130	0.792130	0.792130	72
73	Drugs Charged to Patients	1,747,555	4,949,216	6,696,771	0.315719	0.315719	0.315719	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		3,594,775	3,594,775				88
90	Clinic		1,277,099	1,277,099	0.553039	0.553039	0.553039	90
90.01	WOUND CARE							90.01
90.02	CLINIC		363,709	363,709	1.068750	1.068750	1.068750	90.02
90.03	URGENT CARE		1,180,673	1,180,673	0.800393	0.800393	0.800393	90.03
90.04	CISNE CLINIC		68,040	68,040	1.847325	1.847325	1.847325	90.04
91	Emergency	88,123	3,490,575	3,578,698	0.582144	0.582144	0.582144	91
92	Observation Beds (Non-Distinct Part)	159,918	906,750	1,066,668	0.839488	0.839488	0.839488	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		561,116	561,116				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	17,669,492	67,456,652	85,126,144				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	17,669,492	67,456,652	85,126,144				202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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	3,126,491		3,126,491		3,126,491	30
31	Intensive Care Unit	377,984		377,984		377,984	31
44	Skilled Nursing Facility	2,249,778		2,249,778		2,249,778	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,145,200		2,145,200		2,145,200	50
54	Radiology-Diagnostic	2,420,339		2,420,339		2,420,339	54
60	Laboratory	2,700,273		2,700,273		2,700,273	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	455,129		455,129		455,129	65
66	Physical Therapy	1,256,111		1,256,111		1,256,111	66
69	Electrocardiology	66,879		66,879		66,879	69
71	Medical Supplies Charged to Patients	915,240		915,240		915,240	71
72	Impl. Dev. Charged to Patients	109,973		109,973		109,973	72
73	Drugs Charged to Patients	2,114,300		2,114,300		2,114,300	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	4,133,977		4,133,977		4,133,977	88
90	Clinic	706,285		706,285		706,285	90
90.01	WOUND CARE						90.01
90.02	CLINIC	388,714		388,714		388,714	90.02
90.03	URGENT CARE	945,002		945,002		945,002	90.03
90.04	CISNE CLINIC	125,692		125,692		125,692	90.04
91	Emergency	2,083,317		2,083,317		2,083,317	91
92	Observation Beds (Non-Distinct Part)	895,455		895,455		895,455	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	578,698		578,698		578,698	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	27,794,837		27,794,837		27,794,837	200
201	Less Observation Beds	895,455		895,455		895,455	201
202	Total (line 200 minus line 201)	26,899,382		26,899,382		26,899,382	202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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**

		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							30
31	Intensive Care Unit							31
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	WOUND CARE							90.01
90.02	CLINIC							90.02
90.03	URGENT CARE							90.03
90.04	CISNE CLINIC							90.04
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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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	2,145,200	157,441	1,987,759		50
54	Radiology-Diagnostic	2,420,339	124,985	2,295,354		54
60	Laboratory	2,700,273	86,538	2,613,735		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	455,129	39,745	415,384		65
66	Physical Therapy	1,256,111	88,632	1,167,479		66
69	Electrocardiology	66,879	1,275	65,604		69
71	Medical Supplies Charged to Patients	915,240	46,001	869,239		71
72	Impl. Dev. Charged to Patients	109,973	1,365	108,608		72
73	Drugs Charged to Patients	2,114,300	79,162	2,035,138		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	4,133,977	332,381	3,801,596		88
90	Clinic	706,285	42,373	663,912		90
90.01	WOUND CARE					90.01
90.02	CLINIC	388,714	25,857	362,857		90.02
90.03	URGENT CARE	945,002	54,231	890,771		90.03
90.04	CISNE CLINIC	125,692	13,945	111,747		90.04
91	Emergency	2,083,317	79,329	2,003,988		91
92	Observation Beds (Non-Distinct Part)	895,455	92,510	802,945		92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	578,698	41,874	536,824		101
113	Interest Expense					113
200	Subtotal	22,040,584	1,307,644	20,732,940		200
201	Less Observation Beds	895,455	92,510	802,945		201
202	Total	21,145,129	1,215,134	19,929,995		202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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		2,145,200			50
54	Radiology-Diagnostic		2,420,339			54
60	Laboratory		2,700,273			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		455,129			65
66	Physical Therapy		1,256,111			66
69	Electrocardiology		66,879			69
71	Medical Supplies Charged to Patients		915,240			71
72	Impl. Dev. Charged to Patients		109,973			72
73	Drugs Charged to Patients		2,114,300			73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic		4,133,977			88
90	Clinic		706,285			90
90.01	WOUND CARE					90.01
90.02	CLINIC		388,714			90.02
90.03	URGENT CARE		945,002			90.03
90.04	CISNE CLINIC		125,692			90.04
91	Emergency		2,083,317			91
92	Observation Beds (Non-Distinct Part)		895,455	1,066,668	0.839488	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		578,698			101
113	Interest Expense					113
200	Subtotal		22,040,584	1,066,668		200
201	Less Observation Beds		895,455	1,066,668		201
202	Total		21,145,129			202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1311

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	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	0.142269		3,911,624			556,503		50
54	Radiology-Diagnostic	0.131251		7,690,106			1,009,334		54
60	Laboratory	0.210688		5,138,691			1,082,661		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.080981		931,654			75,446		65
66	Physical Therapy	0.385262		771,634			297,281		66
69	Electrocardiology	0.052433		477,128			25,017		69
71	Medical Supplies Charged to Pat	0.216614		1,469,556			318,326		71
72	Impl. Dev. Charged to Patients	0.792130		131,810			104,411		72
73	Drugs Charged to Patients	0.315719		2,701,365			852,872		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.553039		1,228,683			679,510		90
90.01	WOUND CARE								90.01
90.02	CLINIC	1.068750		208,749			223,100		90.02
90.03	URGENT CARE	0.800393		286			229		90.03
90.04	CISNE CLINIC	1.847325							90.04
91	Emergency	0.582144		1,296,167			754,556		91
92	Observation Beds (Non-Distinct	0.839488		537,585			451,296		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			26,495,038			6,430,542		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			26,495,038			6,430,542		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5552

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☐ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☒ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ 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
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
90	Clinic									90
90.01	WOUND CARE									90.01
90.02	CLINIC									90.02
90.03	URGENT CARE									90.03
90.04	CISNE CLINIC									90.04
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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5552

WORKSHEET D
PART IV

Check [] Title V [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [XX] 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	15,078,527							50
54	Radiology-Diagnostic	18,440,602			74,650				54
60	Laboratory	12,816,450			80,019				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,620,202			435,442				65
66	Physical Therapy	3,260,407			884,097				66
69	Electrocardiology	1,275,518			3,646				69
71	Medical Supplies Charged to Pat	4,225,217			248,861				71
72	Impl. Dev. Charged to Patients	138,832							72
73	Drugs Charged to Patients	6,696,771			352,674				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	3,594,775							88
90	Clinic	1,277,099							90
90.01	WOUND CARE								90.01
90.02	CLINIC	363,709							90.02
90.03	URGENT CARE	1,180,673							90.03
90.04	CISNE CLINIC	68,040							90.04
91	Emergency	3,578,698							91
92	Observation Beds (Non-Distinct	1,066,668							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	78,682,188			2,079,389				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5552

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☒ Title XVIII, Part B

☐ Title XIX - O/P

☐ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☒ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed 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	0.142269							50
54	Radiology-Diagnostic	0.131251							54
60	Laboratory	0.210688							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.080981							65
66	Physical Therapy	0.385262							66
69	Electrocardiology	0.052433							69
71	Medical Supplies Charged to Pat	0.216614							71
72	Impl. Dev. Charged to Patients	0.792130							72
73	Drugs Charged to Patients	0.315719							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.553039							90
90.01	WOUND CARE								90.01
90.02	CLINIC	1.068750							90.02
90.03	URGENT CARE	0.800393							90.03
90.04	CISNE CLINIC	1.847325							90.04
91	Emergency	0.582144							91
92	Observation Beds (Non-Distinct	0.839488							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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V
Applicable [] Title XVIII, Part A
Boxes: [XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	323,000		323,000	2,671	120.93	219	26,484	30
31	Intensive Care Unit	30,739		30,739	201	152.93	39	5,964	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	198,846		198,846	7,846	25.34			44
45	Nursing Facility								45
200	Total (lines 30-199)	552,585		552,585	10,718		258	32,448	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-1311****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	157,441	15,078,527	0.010441			50
54	Radiology-Diagnostic	124,985	18,440,602	0.006778			54
60	Laboratory	86,538	12,816,450	0.006752			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	39,745	5,620,202	0.007072			65
66	Physical Therapy	88,632	3,260,407	0.027184			66
69	Electrocardiology	1,275	1,275,518	0.001000			69
71	Medical Supplies Charged to Pat	46,001	4,225,217	0.010887			71
72	Impl. Dev. Charged to Patients	1,365	138,832	0.009832			72
73	Drugs Charged to Patients	79,162	6,696,771	0.011821			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	332,381	3,594,775	0.092462			88
90	Clinic	42,373	1,277,099	0.033179			90
90.01	WOUND CARE						90.01
90.02	CLINIC	25,857	363,709	0.071093			90.02
90.03	URGENT CARE	54,231	1,180,673	0.045932			90.03
90.04	CISNE CLINIC	13,945	68,040	0.204953			90.04
91	Emergency	79,329	3,578,698	0.022167			91
92	Observation Beds (Non-Distinct	92,510	1,066,668	0.086728			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,265,770	78,682,188				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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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)	2,671		219		30
31	Intensive Care Unit	201		39		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	7,846				44
45	Nursing Facility					45
200	Total (lines 30-199)	10,718		258		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1311

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ 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
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
90	Clinic									90
90.01	WOUND CARE									90.01
90.02	CLINIC									90.02
90.03	URGENT CARE									90.03
90.04	CISNE CLINIC									90.04
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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1311

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ 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
54	Radiology-Diagnostic								54
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic								90
90.01	WOUND CARE								90.01
90.02	CLINIC								90.02
90.03	URGENT CARE								90.03
90.04	CISNE CLINIC								90.04
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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1311

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☐ Title XVIII, Part B

☒ Title XIX - O/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed 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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
54	Radiology-Diagnostic								54
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic								90
90.01	WOUND CARE								90.01
90.02	CLINIC								90.02
90.03	URGENT CARE								90.03
90.04	CISNE CLINIC								90.04
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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1311****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)	2,671	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,671	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)	1,906	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)	1,200	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	188.27	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	192.90	20
21	Total general inpatient routine service cost (see instructions)	3,126,491	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)	3,126,491	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,126,491	37

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1311****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)						1,170.53	38
39	Program general inpatient routine service cost (line 9 x line 38)						1,404,636	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)						1,404,636	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	377,984	201	1,880.52	110	206,857		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)						988,372	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						2,599,865	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							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)							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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1311

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)					765	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,170.53	88
89	Observation bed cost (line 87 x line 88) (see instructions)					895,455	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	323,000	3,126,491	0.103311	895,455	92,510	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-5552****WORKSHEET D-1
PART I**

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

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,846	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,846	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)	7,846	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)	1,806	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)	2,249,778	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)	2,249,778	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,249,778	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-5552****WORKSHEET D-1
PARTS III & IV**

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 III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,249,778	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	286.74	71
72	Program routine service cost (line 9 x line 71)	517,852	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	517,852	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	517,852	83
84	Program inpatient ancillary services (see instructions)	567,973	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	1,085,825	86

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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1311****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)	2,671	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,671	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)	1,906	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)	219	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	188.27	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	192.90	20
21	Total general inpatient routine service cost (see instructions)	3,126,491	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)	3,126,491	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,126,491	37

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1311****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)						1,170.53	38
39	Program general inpatient routine service cost (line 9 x line 38)						256,346	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)						256,346	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	377,984	201	1,880.52	39	73,340		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)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						329,686	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						32,448	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)						32,448	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1311

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)					765	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,170.53	88
89	Observation bed cost (line 87 x line 88) (see instructions)					895,455	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	323,000	3,126,491	0.103311	895,455	92,510	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1311

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,411,200		30
31	Intensive Care Unit		213,510		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.142269	832,613	118,455	50
54	Radiology-Diagnostic	0.131251	623,585	81,846	54
60	Laboratory	0.210688	795,752	167,655	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.080981	1,155,706	93,590	65
66	Physical Therapy	0.385262	118,258	45,560	66
69	Electrocardiology	0.052433	82,350	4,318	69
71	Medical Supplies Charged to Patients	0.216614	792,274	171,618	71
72	Impl. Dev. Charged to Patients	0.792130	7,022	5,562	72
73	Drugs Charged to Patients	0.315719	809,774	255,661	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.553039			90
90.01	WOUND CARE				90.01
90.02	CLINIC	1.068750			90.02
90.03	URGENT CARE	0.800393			90.03
90.04	CISNE CLINIC	1.847325			90.04
91	Emergency	0.582144	41,783	24,324	91
92	Observation Beds (Non-Distinct Part)	0.839488	23,565	19,783	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,282,682	988,372	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,282,682		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-5552

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
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.142269			50
54	Radiology-Diagnostic	0.131251	74,650	9,798	54
60	Laboratory	0.210688	80,019	16,859	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.080981	435,442	35,263	65
66	Physical Therapy	0.385262	884,097	340,609	66
69	Electrocardiology	0.052433	3,646	191	69
71	Medical Supplies Charged to Patients	0.216614	248,861	53,907	71
72	Impl. Dev. Charged to Patients	0.792130			72
73	Drugs Charged to Patients	0.315719	352,674	111,346	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.553039			90
90.01	WOUND CARE				90.01
90.02	CLINIC	1.068750			90.02
90.03	URGENT CARE	0.800393			90.03
90.04	CISNE CLINIC	1.847325			90.04
91	Emergency	0.582144			91
92	Observation Beds (Non-Distinct Part)	0.839488			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,079,389	567,973	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,079,389		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-1311****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)	6,430,542			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)				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)	6,430,542			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)				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)	6,494,847			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)	112,598			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,246,372			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)	2,135,877			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)	2,135,877			30
31	Primary payer payments	409			31
32	Subtotal (line 30 minus line 31)	2,135,468			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)	880,258			34
35	Adjusted reimbursable bad debts (see instructions)	572,168			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	31,240			36
37	Subtotal (see instructions)	2,707,636			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)	2,707,636			40
40.01	Sequestration adjustment (see instructions)	54,153			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,444,076			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	209,407			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-5552****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)				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)				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)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				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)				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

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WORKSHEET E-1
PART I

				INPATIENT PART A		PART B		
DESCRIPTION				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
				1	2	3	4	
1	Total interim payments paid to provider				1,977,504		2,444,076	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)			01/31/2018	75,900			3.01
								3.02
		Program						3.03
		to						3.04
		Provider						3.05
								3.06
								3.07
								3.08
								3.09
								3.10
								3.50
								3.51
		Provider						3.52
		to						3.53
		Program						3.54
								3.55
								3.56
								3.57
								3.58
								3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)				75,900			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)				2,053,404		2,444,076	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)							5.01
								5.02
		Program						5.03
		to						5.04
		Provider						5.05
								5.06
								5.07
								5.08
								5.09
								5.10
								5.50
								5.51
		Provider						5.52
		to						5.53
		Program						5.54
								5.55
								5.56
								5.57
								5.58
								5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)							5.99
6	Determined net settlement amount (balance due) based on the cost report (1)				169,656		209,407	6.01
								6.02
7	Total Medicare program liability (see instructions)				2,223,060		2,653,483	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART V****PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT**

1	Inpatient services	2,599,865	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,599,865	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,625,864	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	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)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,625,864	19
20	Deductibles (exclude professional component)	414,348	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,211,516	22
23	Coinsurance	670	23
24	Subtotal (line 22 minus line 23)	2,210,846	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	88,589	25
26	Adjusted reimbursable bad debts (see instructions)	57,583	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,672	27
28	Subtotal (sum of lines 24 and 26)	2,268,429	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,268,429	30
30.01	Sequestration adjustment (see instructions)	45,369	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	2,053,404	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	169,656	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART VI****PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES**

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment		1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)		4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance		7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)		12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)		15
15.01	Sequestration adjustment (see instructions)		15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments		16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1311

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	329,686		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	329,686		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	329,686		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 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)			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)			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)	329,686		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)	329,686		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	329,686		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)	329,686		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	329,686		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)	329,686		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	329,686		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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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)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	328,105				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,504,772				4
5	Other receivables	1,034,212				5
6	Allowances for uncollectible notes and accounts receivable	-3,238,770				6
7	Inventory	618,239				7
8	Prepaid expenses	511,164				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	6,757,722				11
	FIXED ASSETS					
12	Land	449,428				12
13	Land improvements	657,953				13
14	Accumulated depreciation	-606,014				14
15	Buildings	24,318,008				15
16	Accumulated depreciation	-13,487,267				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	1,887,078				19
20	Accumulated depreciation	-1,310,635				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,148,647				23
24	Accumulated depreciation	-9,894,653				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)	13,162,545				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,412,770				34
35	Total other assets (sum of lines 31-34)	4,412,770				35
36	Total assets (sum of lines 11, 30 and 35)	24,333,037				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	544,690				37
38	Salaries, wages and fees payable	1,099,911				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	598,920				40
41	Deferred income	165,747				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	408,790				44
45	Total current liabilities (sum of lines 37 thru 44)	2,818,058				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	5,645,165				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	5,645,165				50
51	Total liabilities (sum of lines 45 and 50)	8,463,223				51
	CAPITAL ACCOUNTS					
52	General fund balance	15,869,814				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)	15,869,814				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	24,333,037				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		15,380,346		1
2	Net income (loss) (from Worksheet G-3, line 29)		529,165		2
3	Total (sum of line 1 and line 2)		15,909,511		3
4	Additions (credit adjustments) (specify)				4
5	PRIOR YEAR ADJUSTMENTS				5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		15,909,511		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,909,511		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	PRIOR YEAR ADJUSTMENTS				5
6					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					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

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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	4,245,583		4,245,583	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,282,054		1,282,054	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	5,527,637		5,527,637	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	355,203		355,203	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)	355,203		355,203	16
17	Total inpatient routine care services (sum of lines 10 and 16)	5,882,840		5,882,840	17
18	Ancillary services	10,576,230	56,976,296	67,552,526	18
19	Outpatient services	248,041	7,286,846	7,534,887	19
20	Rural Health Clinic (RHC)		3,594,775	3,594,775	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		561,116	561,116	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PRO FEES	376,050	6,164,930	6,540,980	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	17,083,161	74,583,963	91,667,124	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		30,708,358	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		30,708,358	43

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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)	91,667,124	1
2	Less contractual allowances and discounts on patients' accounts	61,802,802	2
3	Net patient revenues (line 1 minus line 2)	29,864,322	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	30,708,358	4
5	Net income from service to patients (line 3 minus line 4)	-844,036	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	143,520	6
7	Income from investments	90,119	7
8	Revenues from telephone and other miscellaneous communication services	131	8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	2,140	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	182,267	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	9,653	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	205,008	22
23	Governmental appropriations		23
24	Other (MISCELLANEOUS)	179,160	24
24.01	Other (GRANTS)	88,408	24.01
24.02	Other (DEFERRED REVENUE)	169,440	24.02
24.03	Other (SITE FEES)		24.03
24.04	Other (EHR INCENTIVE)		24.04
24.05	Other (SALE OF SCRAP)	359	24.05
24.06	Other (340B)	302,996	24.06
25	Total other income (sum of lines 6-24)	1,373,201	25
26	Total (line 5 plus line 25)	529,165	26
29	Net income (or loss) for the period (line 26 minus line 28)	529,165	29

KPMG LLP Compu-Max 2552-10

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 14-7612****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	34,691		36,574	12,726	20,771	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	147,532					6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech Pathology						9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)						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	94,704					23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	276,927		36,574	12,726	20,771	24

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHH CCN: 14-7612

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	104,762		104,762		104,762	5
	HHH REIMBURSABLE SERVICES						
6	Skilled Nursing Care	147,532		147,532		147,532	6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech Pathology						9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHH 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	94,704		94,704		94,704	23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	346,998		346,998		346,998	24

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

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 14-7612****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	104,762				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	147,532				6
7	Physical Therapy					7
8	Occupational Therapy					8
9	Speech Pathology					9
10	Medical Social Services					10
11	Home Health Aide					11
12	Supplies (see instructions)					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	94,704				23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	346,998				24

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHA CCN: 14-7612****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		104,762	104,762		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		147,532	63,805	211,337	6
7	Physical Therapy					7
8	Occupational Therapy					8
9	Speech Pathology					9
10	Medical Social Services					10
11	Home Health Aide					11
12	Supplies (see instructions)					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		94,704	40,957	135,661	23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		346,998		346,998	24

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - HHA STATISTICAL BASIS
HHA CCN: 14-7612
**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					-104,762	242,236	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						147,532	6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech Pathology							9
10	Medical Social Services							10
11	Home Health Aide							11
12	Supplies (see instructions)							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						94,704	23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-104,762	242,236	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						104,762	25
26	Unit Cost Multiplier						0.432479	26

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**HHA CCN: 14-7612****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		21,661	10,912	8,657	41,230	6,440	1
2	Skilled Nursing Care	211,337			36,815	248,152	38,758	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	135,661			23,632	159,293	24,879	19
20	Totals (sum of lines 1-19)(2)	346,998	21,661	10,912	69,104	448,675	70,077	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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**HHA CCN: 14-7612****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	20,238	19,071		20,637			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)	20,238	19,071		20,637			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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7612

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							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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS**HHA CCN: 14-7612****WORKSHEET H-2
PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						107,616	1
2	Skilled Nursing Care						286,910	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						184,172	19
20	Totals (sum of lines 1-19)(2)						578,698	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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7612

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtlI)	TOTAL HHA COSTS			
		25	26	27	28			
1	Administrative and General		107,616					1
2	Skilled Nursing Care		286,910	65,543	352,453			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		184,172	42,073	226,245			19
20	Totals (sum of lines 1-19)(2)		578,698	107,616	578,698			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.			0.228444				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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS**HHA CCN: 14-7612****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	1,920	1,920	34,691		41,230	1,920	1
2	Skilled Nursing Care			147,532		248,152		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			94,704		159,293		19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	1,920	1,920	276,927		448,675	1,920	20
21	Total cost to be allocated	21,661	10,912	69,104		70,077	20,238	21
22	Unit Cost Multiplier	11.281771		0.249539		0.156187		22
22	Unit Cost Multiplier		5.683333				10.540625	22

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS**HHA CCN: 14-7612****WORKSHEET H-2
PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERV ED	CAFETERIA FTE'S SERV ED	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General	1,920		1,920				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)	1,920		1,920				20
21	Total cost to be allocated	19,071		20,637				21
22	Unit Cost Multiplier	9.932813		10.748438				22
22	Unit Cost Multiplier							22

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7612

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING ADMINIS- TRATION DIRECT NRS ING HRS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	PHARMACY COSTED REQ UIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE ASSIGNED TIME	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7612

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			
		20	21	22	23			
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

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APPORTIONMENT OF PATIENT SERVICE COSTS**HHA CCN: 14-7612****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	352,453		352,453	2,195	160.57	1
2	Physical Therapy	3				773		2
3	Occupational Therapy	4				277		3
4	Speech Pathology	5				24		4
5	Medical Social Services	6						5
6	Home Health Aide	7				218		6
7	Total (sum of lines 1-6)		352,453		352,453	3,487		7

Limitation Cost Computation								
				Program Visits				
				PART B				
	Patient Services		CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			1	2	3	4		
8	Skilled Nursing Care		14999		1,372			8
9	Physical Therapy		14999		568			9
10	Occupational Therapy		14999		185			10
11	Speech Pathology		14999		13			11
12	Medical Social Services		14999					12
13	Home Health Aide		14999					13
14	Total (sum of lines 8-13)				2,138			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						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	0.385262			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.216614			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.315719			col. 2, line 16	5

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7612

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		1,372			220,302		220,302	1
2	Physical Therapy		568						2
3	Occupational Therapy		185						3
4	Speech Pathology		13						4
5	Medical Social Services								5
6	Home Health Aide								6
7	Total (sum of lines 1-6)		2,138			220,302		220,302	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								15
16	Cost of Drugs								16

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT**HHA CCN: 14-7612****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**

		Part B			
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				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		324,078	11
12	Total PPS Reimbursement - Full Episodes with Outliers		11,698	12
13	Total PPS Reimbursement - LUPA Episodes		11,429	13
14	Total PPS Reimbursement - PEP Episodes		4,033	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		10,722	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)		361,960	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		361,960	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		361,960	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)		361,960	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		361,960	31
31.01	Sequestration adjustment (see instructions)		7,239	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		354,722	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)		-1	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM HHA CCN: 14-7612
BENEFICIARIES

WORKSHEET H-5

	DESCRIPTION		mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider					354,722	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)						
		Program	.01				3.01
			.02				3.02
		To	.03				3.03
		Provider	.04				3.04
			.05				3.05
			.06				3.06
			.07				3.07
			.08				3.08
			.09				3.09
			.10				3.10
			.50				3.50
			.51				3.51
		Provider	.52				3.52
		To	.53				3.53
		Program	.54				3.54
			.55				3.55
			.56				3.56
			.57				3.57
			.58				3.58
			.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)					354,722	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)						
		Program	.01				5.01
			.02				5.02
		To	.03				5.03
		Provider	.04				5.04
			.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	Determine net settlement amount (balance due) based on the cost report (see instructions)		.01				6.01
			.02			-1	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					354,721	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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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
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	WOUND CARE							90.01
90.02	CLINIC							90.02
90.03	URGENT CARE							90.03
90.04	CISNE CLINIC							90.04
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							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

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**ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS**
COMPONENT CCN: 14-8500
WORKSHEET M-1

Check applicable box: ☒ RHC I ☐ FQHC

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	989,624		989,624	66,846	1,056,470	-100,003	956,467	1
2	Physician Assistant	289,620		289,620		289,620		289,620	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker	138,002		138,002		138,002		138,002	7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	1,417,246		1,417,246	66,846	1,484,092	-100,003	1,384,089	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)								21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,417,246		1,417,246	66,846	1,484,092	-100,003	1,384,089	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	680,483	223,666	904,149	640	904,789		904,789	30
31	Total Facility Overhead (sum of lines 29 and 30)	680,483	223,666	904,149	640	904,789		904,789	31
32	Total facility costs (sum of lines 22, 28 and 31)	2,097,729	223,666	2,321,395	67,486	2,388,881	-100,003	2,288,878	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES**COMPONENT CCN: 14-8500****WORKSHEET M-2**

Check applicable box: ☒ RHC **I** ☐ FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	3.29	13,582	4,200	13,818		1
2	Physician Assistants	2.39	6,753	2,100	5,019		2
3	Nurse Practitioners			2,100			3
4	Subtotal (sum of lines 1 through 3)	5.68	20,335		18,837	20,335	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker	1.75	3,649			3,649	7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	7.43	23,984			23,984	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		1,384,089	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)			11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		1,384,089	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)		904,789	14
15	Parent provider overhead allocated to facility (see instructions)		1,845,099	15
16	Total overhead (sum of lines 14 and 15)		2,749,888	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		2,749,888	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		2,749,888	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		4,133,977	20

- (1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-8500

WORKSHEET M-3

Check applicable boxes: ☒ RHC I ☐ Title V ☐ Title XIX
☐ FQHC ☒ Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	4,133,977	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	138,384	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	3,995,593	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	23,984	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	23,984	6
7	Adjusted cost per visit (line 3 divided by line 6)	166.59	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	166.59	166.59	166.59	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		6,453		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,075,005		11
12	Program covered visits for mental health services (from contractor records)		72		12
13	Program covered cost from mental health services (line 9 x line 12)		11,994		13
14	Limit adjustment for mental health services (see instructions)		11,994		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,086,999		16
16.01	Total program charges (see instructions)(from contractor's records)		787,221		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		54,895		16.02
16.03	Total program preventive costs (see instructions)		75,800		16.03
16.04	Total program non-preventive costs (see instructions)		743,623		16.04
16.05	Total program cost (see instructions)		819,423		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		81,670		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		141,110		19
20	Net Medicare cost excluding vaccines (see instructions)		819,423		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		101,542		21
22	Total reimbursable Program cost (line 20 plus line 21)		920,965		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		920,965		26
26.01	Sequestration adjustment (see instructions)		18,419		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		742,435		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		160,111		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-8500

WORKSHEET M-4

Check applicable boxes: ☒ RHC I ☐ Title V ☐ Title XIX
☐ FQHC ☒ Title XVIII

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,384,089	1,384,089	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001757	0.004378	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,432	6,060	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	22,695	15,145	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	25,127	21,205	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,384,089	1,384,089	6
7	Total overhead (from Wkst. M-2, line 16)	2,749,888	2,749,888	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018154	0.015321	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	49,921	42,131	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	75,048	63,336	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	181	451	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	414.63	140.43	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	146	292	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	60,536	41,006	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		138,384	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		101,542	16

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/21/2018 Run Time: 12:55 Version: 2018.04 (09/26/2018)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8500

WORKSHEET M-5

Check applicable box: ☒ RHC I ☐ FQHC

			Part B		
DESCRIPTION			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider			742,435	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 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 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. M-3, line 27)			742,435	
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 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	Determine net settlement amount (balance due) based on the cost report (1)	.01		160,111	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			902,546	
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 you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.