

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report Date: 11/26/2019 Time: 11:35 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 07/01/2018 and ending 06/30/2019, 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) AMY L. MARSH
 Chief Financial Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

11/26/2019 11:35
 Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		27,246	-82,475		314,607	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			74,353			10
10.01	HEALTH CLINIC - RHC II						10.01
10.02	HEALTH CLINIC - RHC III						10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		27,246	-8,121		314,607	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)			
	0	1	2	3	4	5	V	XVIII	XIX	
3	Hospital	FAIRFIELD MEMORIAL HOSPITAL	14-1311	99914	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	99914		03 / 26 / 1985	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	14-7612	99914		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	99914		03 / 13 / 2009	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	HORIZON HEALTHCARE	14-8591	99914		07 / 12 / 2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	HORIZON HEALTHCARE GRAYVILLE	14-8602	99914		05 / 24 / 2019	N	O	N	15.02
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 / 2018	To: 06 / 30 / 2019	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 paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

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 is in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)			37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	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
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.		1 N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	1 N	2	111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-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 292,033	Paid Losses 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 §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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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 / 2018	06 / 30 / 2019	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

		Y/N	
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	11/20/2019	Y	11/20/2019	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 relined 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	34,968.00		955	195	1,457	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	34,968.00		955	195	1,457	7
8	Intensive Care Unit	31	4	1,460	5,304.00		126	42	221	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	40,272.00		1,081	237	1,678	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			1,637		7,327	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					3,289	570	4,775	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					6,869	9,886	30,690	26
26.01	RHC II	88.01								26.01
26.02	RHC III	88.02								26.02
27	Total (sum of lines 14-26)		55							27
28	Observation Bed Days								843	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)					374	83	561	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)		207.40			374	83	561	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		19.88						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		30.35						26
26.01	RHC II								26.01
26.02	RHC III								26.02
27	Total (sum of lines 14-26)		257.63						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	1,209	649	45	9	1,912	21
22	Skilled Nursing Visit Charges	132,558	73,550	4,640	928	211,676	22
23	Physical Therapy Visits	967	78	16	17	1,078	23
24	Physical Therapy Visit Charges	110,294	9,042	1,508	1,972	122,816	24
25	Occupational Therapy Visits	220	20	3	7	250	25
26	Occupational Therapy Visit Charges	24,938	2,320	232	812	28,302	26
27	Speech Pathology Visits	47	1			48	27
28	Speech Pathology Visit Charges	5,598	121			5,719	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits	1				1	31
32	Home Health Aide Visit Charges	62				62	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,444	748	64	33	3,289	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	273,450	85,033	6,380	3,712	368,575	35
36	Total Number of Episodes (standard/non-outlier)						36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges	6,223	4,066	2,142	2	12,433	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	14		14	7
8	RHL	1		1	8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	97		97	12
13	RUB	71		71	13
14	RUA	249		249	14
15	RVC	189		189	15
16	RVB	151		151	16
17	RVA	643		643	17
18	RHC	60		60	18
19	RHB	48		48	19
20	RHA	64		64	20
21	RMC				21
22	RMB	6		6	22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	3		3	28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1	1		1	32
33	HC2	14		14	33
34	HC1				34
35	HB2	1		1	35
36	HB1	14		14	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	1		1	48
49	CC2				49
50	CC1	2		2	50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1	3		3	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				74
75	PB2				75
76	PB1	5		5	76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL	1,637		1,637	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)	1,248,915			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)	0.318968	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,016,576	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	2,750,138	5
6	Medicaid charges	15,789,249	6
7	Medicaid cost (line 1 times line 6)	5,036,265	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,269,551	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

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

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,269,551	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)	619,062		619,062	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	197,461		197,461	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)	197,461		197,461	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)	2,946,675	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	836,953	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,287,620	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,659,055	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	979,852	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,177,313	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,446,864	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		1,459,046	1,459,046	172,529	1,631,575	-421,899	1,209,676	1
2	00200	Cap Rel Costs-Mvble Equip		517,904	517,904		517,904		517,904	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		3,229,253	3,229,253		3,229,253		3,229,253	4
5	00500	Administrative & General	1,518,545	2,848,686	4,367,231		4,367,231	-1,292,402	3,074,829	5
6	00600	Maintenance & Repairs	332,930	246,740	579,670		579,670		579,670	6
7	00700	Operation of Plant		623,006	623,006		623,006		623,006	7
8	00800	Laundry & Linen Service		409,783	409,783		409,783		409,783	8
9	00900	Housekeeping	364,358	141,285	505,643		505,643		505,643	9
10	01000	Dietary	380,700	325,158	705,858	-426,458	279,400		279,400	10
11	01100	Cafeteria				426,458	426,458	-202,680	223,778	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	272,821	18,742	291,563		291,563		291,563	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	280,601	148,553	429,154		429,154	-14,280	414,874	16
17	01700	Social Service	120,554	4,411	124,965		124,965		124,965	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	1,208,333	189,727	1,398,060		1,398,060	-141,364	1,256,696	30
31	03100	Intensive Care Unit	150,876	5,745	156,621		156,621		156,621	31
44	04400	Skilled Nursing Facility	799,878	63,134	863,012		863,012		863,012	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,151,842	368,847	1,520,689		1,520,689	-470,356	1,050,333	50
54	05400	Radiology-Diagnostic	572,920	1,028,681	1,601,601		1,601,601		1,601,601	54
60	06000	Laboratory	837,989	1,148,634	1,986,623		1,986,623		1,986,623	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	188,448	136,335	324,783	-73,822	250,961		250,961	65
66	06600	Physical Therapy	880,218	13,269	893,487		893,487		893,487	66
69	06900	Electrocardiology				73,822	73,822	-35,393	38,429	69
71	07100	Medical Supplies Charged to Patients	55,401	583,091	638,492	-121,083	517,409		517,409	71
72	07200	Impl. Dev. Charged to Patients				121,083	121,083		121,083	72
73	07300	Drugs Charged to Patients	240,965	1,400,051	1,641,016		1,641,016		1,641,016	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	2,509,082	515,729	3,024,811	-135,684	2,889,127	-71,305	2,817,822	88
90	09000	Clinic	420,253	137,037	557,290	-87,199	470,091		470,091	90
90.01	09001	WOUND CARE								90.01
90.02	09002	CLINIC	134,483	45,415	179,898		179,898		179,898	90.02
90.03	09003	URGENT CARE	529,277	15,222	544,499		544,499		544,499	90.03
90.04	09004	CISNE CLINIC								90.04
91	09100	Emergency	733,391	1,963,900	2,697,291		2,697,291	-1,293,978	1,403,313	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	358,841	95,538	454,379		454,379		454,379	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		306,351	306,351	-172,529	133,822	-133,822		113
118		SUBTOTALS (sum of lines 1-117)	14,042,706	17,989,273	32,031,979	-222,883	31,809,096	-4,077,479	27,731,617	118
		NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE								190.01
192	19200	Physicians' Private Offices				222,883	222,883		222,883	192
200		TOTAL (sum of lines 118-199)	14,042,706	17,989,273	32,031,979		32,031,979	-4,077,479	27,954,500	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	230,007	196,451	1
500	Total reclassifications				230,007	196,451	500
	Code Letter - A						
1	TO RECLASS EKG	B	Electrocardiology	69	38,429	35,393	1
500	Total reclassifications				38,429	35,393	500
	Code Letter - B						
1	TO RECLASS INTEREST	C	Cap Rel Costs-Bldg & Fixt	1		172,529	1
500	Total reclassifications					172,529	500
	Code Letter - C						
1	TO RECLASS IMPLANTABLE DEVICES	D	Impl. Dev. Charged to Patient	72		121,083	1
500	Total reclassifications					121,083	500
	Code Letter - D						
1	BAHAVIORAL HEALTH	E	Rural Health Clinic	88	80,950	6,249	1
500	Total reclassifications				80,950	6,249	500
	Code Letter - E						
1	RECLASS CLINIC COSTS PRIOR TO RHC	F	Physicians' Private Offices	192	144,487	78,396	1
500	Total reclassifications				144,487	78,396	500
	Code Letter - F						
	GRAND TOTAL (Increases)				493,873	610,101	

(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	230,007	196,451		1
500	Total reclassifications				230,007	196,451		500
	Code letter - A							
1	TO RECLASS EKG	B	Respiratory Therapy	65	38,429	35,393		1
500	Total reclassifications				38,429	35,393		500
	Code letter - B							
1	TO RECLASS INTEREST	C	Interest Expense	113		172,529	11	1
500	Total reclassifications					172,529		500
	Code letter - C							
1	TO RECLASS IMPLANTABLE DEVICES	D	Medical Supplies Charged to P	71		121,083		1
500	Total reclassifications					121,083		500
	Code letter - D							
1	BAHAVIORAL HEALTH	E	Clinic	90	80,950	6,249		1
500	Total reclassifications				80,950	6,249		500
	Code letter - E							
1	RECLASS CLINIC COSTS PRIOR TO RHC	F	Rural Health Clinic	88	144,487	78,396		1
500	Total reclassifications				144,487	78,396		500
	Code letter - F							
	GRAND TOTAL (Decreases)				493,873	610,101		

(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	657,953					657,953		2
3	Buildings and Fixtures	24,318,009	85,134		85,134		24,403,143		3
4	Building Improvements								4
5	Fixed Equipment	1,887,078	95,328		95,328		1,982,406		5
6	Movable Equipment	9,761,068	884,839		884,839	201,526	10,444,381		6
7	HIT-designated Assets	1,435,870					1,435,870		7
8	Subtotal (sum of lines 1-7)	38,509,406	1,065,301		1,065,301	201,526	39,373,181		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	38,509,406	1,065,301		1,065,301	201,526	39,373,181		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	1,459,046						1,459,046	1
2	Cap Rel Costs-Mvble Equip	517,904						517,904	2
3	Total (sum of lines 1-2)	1,976,950						1,976,950	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	1,459,046		1,459,046	0.738029					1
2	Cap Rel Costs-Mvble Equip	517,904		517,904	0.261971					2
3	Total (sum of lines 1-2)	1,976,950		1,976,950	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	1,037,147		172,529				1,209,676	1
2	Cap Rel Costs-Mvble Equip	517,904						517,904	2
3	Total (sum of lines 1-2)	1,555,051		172,529				1,727,580	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	-133,822	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	-2,524	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	-1,941,091				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-202,680	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	-14,280	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	-94,797	Cap Rel Costs-Bldg & Fixt	1	9	33
33.01	RINARD & WEBER CLINIC	A	-7,662	Cap Rel Costs-Bldg & Fixt	1	9	33.01
33.02	RECRUITING	A	-143,956	Administrative & General	5		33.02
33.03	ADVERTISING	A	-291,100	Administrative & General	5		33.03
33.05	WAYFAIR RENTAL	B	-150,000	Cap Rel Costs-Bldg & Fixt	1	9	33.05
33.06	PROVIDER TAX	A	-845,579	Administrative & General	5		33.06
34	HOSPITALIST IN RHC	A	-71,305	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	-9,243	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)		-4,077,479				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	54	Radiology-Diagnostic	MRI	271,231	271,231			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			271,231	271,231			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	117,311	117,311						1
2	30	Adults & Pediatrics								2
3	30	Adults & Pediatrics AGGREGATE	24,053	24,053						3
4	30	Adults & Pediatrics								4
5	30	Adults & Pediatrics								5
6	50	Operating Room AGGREGATE	470,356	470,356						6
7	50	Operating Room								7
8	50	Operating Room								8
9	60	Laboratory								9
10	69	Electrocardiology AGGREGATE	34,028	34,028						10
11	69	Electrocardiology								11
12	69	Electrocardiology AGGREGATE	1,365	1,365						12
13	91	Emergency AGGREGATE	1,775,491	1,293,978	481,513					13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,422,604	1,941,091	481,513					200

KPMG LLP Compu-Max 2552-10

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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							117,311	1
2	30	Adults & Pediatrics								2
3	30	Adults & Pediatrics AGGREGATE							24,053	3
4	30	Adults & Pediatrics								4
5	30	Adults & Pediatrics								5
6	50	Operating Room AGGREGATE							470,356	6
7	50	Operating Room								7
8	50	Operating Room								8
9	60	Laboratory								9
10	69	Electrocardiology AGGREGATE							34,028	10
11	69	Electrocardiology								11
12	69	Electrocardiology AGGREGATE							1,365	12
13	91	Emergency AGGREGATE							1,293,978	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,941,091	200

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,209,676	1,209,676					1
2	Cap Rel Costs-Mvble Equip	517,904		517,904				2
4	Employee Benefits Department	3,229,253			3,229,253			4
5	Administrative & General	3,074,829	219,207	93,851	349,203	3,737,090	3,737,090	5
6	Maintenance & Repairs	579,670	31,554	13,509	76,560	701,293	108,219	6
7	Operation of Plant	623,006	20,624	8,830		652,460	100,684	7
8	Laundry & Linen Service	409,783	14,251	6,101		430,135	66,376	8
9	Housekeeping	505,643	1,972	844	83,787	592,246	91,392	9
10	Dietary	279,400	1,460	625	34,653	316,138	48,785	10
11	Cafeteria	223,778	42,886	18,361	52,892	337,917	52,145	11
12	Maintenance of Personnel							12
13	Nursing Administration	291,563	1,426	611	62,738	356,338	54,988	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	414,874	16,412	7,027	64,527	502,840	77,595	16
17	Social Service	124,965	1,783	763	27,722	155,233	23,955	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	1,256,696	162,662	69,641	277,867	1,766,866	272,652	30
31	Intensive Care Unit	156,621	14,852	6,359	34,695	212,527	32,796	31
44	Skilled Nursing Facility	863,012	95,298	40,800	183,939	1,183,049	182,561	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,050,333	72,334	30,969	264,876	1,418,512	218,896	50
54	Radiology-Diagnostic	1,601,601	51,008	21,838	131,748	1,806,195	278,721	54
60	Laboratory	1,986,623	25,270	10,819	192,703	2,215,415	341,870	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	250,961	18,763	8,033	34,498	312,255	48,185	65
66	Physical Therapy	893,487	41,660	17,836	202,414	1,155,397	178,294	66
69	Electrocardiology	38,429			8,837	47,266	7,294	69
71	Medical Supplies Charged to Patients	517,409	19,788	8,472	12,740	558,409	86,170	71
72	Impl. Dev. Charged to Patients	121,083				121,083	18,685	72
73	Drugs Charged to Patients	1,641,016	30,395	13,013	55,412	1,739,836	268,481	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	2,817,822	201,314	86,189	562,383	3,667,708	565,984	88
90	Clinic	470,091	19,331	8,276	78,026	575,724	88,842	90
90.01	WOUND CARE							90.01
90.02	CLINIC	179,898	12,089	5,176	30,926	228,089	35,197	90.02
90.03	URGENT CARE	544,499	24,178	10,351	121,712	700,740	108,134	90.03
90.04	CISNE CLINIC							90.04
91	Emergency	1,403,313	25,872	11,077	168,650	1,608,912	248,278	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	454,379	21,393	9,159	82,519	567,450	87,565	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	27,731,617	1,187,782	508,530	3,196,027	27,667,123	3,692,744	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices	222,883	21,894	9,374	33,226	287,377	44,346	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,954,500	1,209,676	517,904	3,229,253	27,954,500	3,737,090	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	809,512						6
7	Operation of Plant	17,411	770,555					7
8	Laundry & Linen Service	12,030	11,703	520,244				8
9	Housekeeping	1,665	1,620	115,743	802,666			9
10	Dietary	1,232	1,199	967	1,354	369,675		10
11	Cafeteria	36,204	35,219		39,785		501,270	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,204	1,171		1,323		11,128	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	13,855	13,478		15,226		22,602	16
17	Social Service	1,505	1,464		1,654		7,770	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	137,319	133,583	144,203	150,902	81,109	65,230	30
31	Intensive Care Unit	12,538	12,197	381	13,778	13,792	6,519	31
44	Skilled Nursing Facility	80,450	78,261	86,084	88,408	274,774	53,482	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	61,064	59,403	2,344	67,104		34,046	50
54	Radiology-Diagnostic	43,061	41,890	42,075	47,320		29,395	54
60	Laboratory	21,333	20,753	7,282	23,443		54,058	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	15,840	15,409	7,840	17,407		10,880	65
66	Physical Therapy	35,169	34,213	12,276	38,648		33,979	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	16,705	16,251		18,358		5,347	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	25,660	24,962		28,198		9,135	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	169,947	165,324	5,655	154,332		81,681	88
90	Clinic	16,319	15,876		17,934		12,738	90
90.01	WOUND CARE							90.01
90.02	CLINIC	10,206	9,928		11,215		6,296	90.02
90.03	URGENT CARE	20,411	19,856	884	22,430		19,876	90.03
90.04	CISNE CLINIC							90.04
91	Emergency	21,841	21,247	92,799	24,001		37,108	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	18,060	17,568		19,846			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	791,029	752,575	518,533	802,666	369,675	501,270	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices	18,483	17,980	1,711				192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	809,512	770,555	520,244	802,666	369,675	501,270	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	426,152						13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		645,596					16
17	Social Service			191,581				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	141,548	40,921	55,808	2,990,141		2,990,141	30
31	Intensive Care Unit	14,146	2,802		321,476		321,476	31
44	Skilled Nursing Facility	116,055	9,379	35,371	2,187,874		2,187,874	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	73,879	92,068		2,027,316		2,027,316	50
54	Radiology-Diagnostic		150,391		2,439,048		2,439,048	54
60	Laboratory		107,747		2,791,901		2,791,901	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		32,317		460,133		460,133	65
66	Physical Therapy		29,366		1,517,342		1,517,342	66
69	Electrocardiology		10,379		64,939		64,939	69
71	Medical Supplies Charged to Patients		37,980		739,220		739,220	71
72	Impl. Dev. Charged to Patients				139,768		139,768	72
73	Drugs Charged to Patients		53,796		2,150,068		2,150,068	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		32,796		4,843,427		4,843,427	88
90	Clinic		9,804		737,237		737,237	90
90.01	WOUND CARE							90.01
90.02	CLINIC		964		301,895		301,895	90.02
90.03	URGENT CARE		6,508		898,839		898,839	90.03
90.04	CISNE CLINIC							90.04
91	Emergency	80,524	28,378	100,402	2,263,490		2,263,490	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency				710,489		710,489	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	426,152	645,596	191,581	27,584,603		27,584,603	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices				369,897		369,897	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	426,152	645,596	191,581	27,954,500		27,954,500	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		219,207	93,851	313,058	313,058		5
6	Maintenance & Repairs		31,554	13,509	45,063	9,066	54,129	6
7	Operation of Plant		20,624	8,830	29,454	8,434	1,164	7
8	Laundry & Linen Service		14,251	6,101	20,352	5,560	804	8
9	Housekeeping		1,972	844	2,816	7,656	111	9
10	Dietary		1,460	625	2,085	4,087	82	10
11	Cafeteria		42,886	18,361	61,247	4,368	2,421	11
12	Maintenance of Personnel							12
13	Nursing Administration		1,426	611	2,037	4,606	81	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		16,412	7,027	23,439	6,500	926	16
17	Social Service		1,783	763	2,546	2,007	101	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		162,662	69,641	232,303	22,840	9,182	30
31	Intensive Care Unit		14,852	6,359	21,211	2,747	838	31
44	Skilled Nursing Facility		95,298	40,800	136,098	15,293	5,379	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		72,334	30,969	103,303	18,337	4,083	50
54	Radiology-Diagnostic		51,008	21,838	72,846	23,349	2,879	54
60	Laboratory		25,270	10,819	36,089	28,639	1,426	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,763	8,033	26,796	4,037	1,059	65
66	Physical Therapy		41,660	17,836	59,496	14,936	2,352	66
69	Electrocardiology					611		69
71	Medical Supplies Charged to Patients		19,788	8,472	28,260	7,219	1,117	71
72	Impl. Dev. Charged to Patients					1,565		72
73	Drugs Charged to Patients		30,395	13,013	43,408	22,491	1,716	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		201,314	86,189	287,503	47,413	11,366	88
90	Clinic		19,331	8,276	27,607	7,442	1,091	90
90.01	WOUND CARE							90.01
90.02	CLINIC		12,089	5,176	17,265	2,949	682	90.02
90.03	URGENT CARE		24,178	10,351	34,529	9,058	1,365	90.03
90.04	CISNE CLINIC							90.04
91	Emergency		25,872	11,077	36,949	20,798	1,460	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		21,393	9,159	30,552	7,335	1,208	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,187,782	508,530	1,696,312	309,343	52,893	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices		21,894	9,374	31,268	3,715	1,236	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,209,676	517,904	1,727,580	313,058	54,129	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	39,052						7
8	Laundry & Linen Service	593	27,309					8
9	Housekeeping	82	6,076	16,741				9
10	Dietary	61	51	28	6,394			10
11	Cafeteria	1,785		830		70,651		11
12	Maintenance of Personnel							12
13	Nursing Administration	59		28		1,568	8,379	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	683		318		3,186		16
17	Social Service	74		34		1,095		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	6,770	7,569	3,147	1,403	9,194	2,783	30
31	Intensive Care Unit	618	20	287	239	919	278	31
44	Skilled Nursing Facility	3,966	4,519	1,844	4,752	7,538	2,282	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,011	123	1,400		4,799	1,453	50
54	Radiology-Diagnostic	2,123	2,209	987		4,143		54
60	Laboratory	1,052	382	489		7,619		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	781	412	363		1,533		65
66	Physical Therapy	1,734	644	806		4,789		66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	824		383		754		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	1,265		588		1,287		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	8,379	297	3,218		11,514		88
90	Clinic	805		374		1,795		90
90.01	WOUND CARE							90.01
90.02	CLINIC	503		234		887		90.02
90.03	URGENT CARE	1,006	46	468		2,801		90.03
90.04	CISNE CLINIC							90.04
91	Emergency	1,077	4,871	501		5,230	1,583	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	890		414				101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	38,141	27,219	16,741	6,394	70,651	8,379	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices	911	90					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	39,052	27,309	16,741	6,394	70,651	8,379	202

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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	35,052					16
17	Social Service		5,857				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	2,223	1,706	299,120		299,120	30
31	Intensive Care Unit	152		27,309		27,309	31
44	Skilled Nursing Facility	510	1,081	183,262		183,262	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,002		141,511		141,511	50
54	Radiology-Diagnostic	8,147		116,683		116,683	54
60	Laboratory	5,854		81,550		81,550	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,756		36,737		36,737	65
66	Physical Therapy	1,595		86,352		86,352	66
69	Electrocardiology	564		1,175		1,175	69
71	Medical Supplies Charged to Patients	2,063		40,620		40,620	71
72	Impl. Dev. Charged to Patients			1,565		1,565	72
73	Drugs Charged to Patients	2,923		73,678		73,678	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	1,782		371,472		371,472	88
90	Clinic	533		39,647		39,647	90
90.01	WOUND CARE						90.01
90.02	CLINIC	52		22,572		22,572	90.02
90.03	URGENT CARE	354		49,627		49,627	90.03
90.04	CISNE CLINIC						90.04
91	Emergency	1,542	3,070	77,081		77,081	91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency			40,399		40,399	101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	35,052	5,857	1,690,360		1,690,360	118
	NONREIMBURSABLE COST CENTERS						
190.01	VENDING MACHINE						190.01
192	Physicians' Private Offices			37,220		37,220	192
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	35,052	5,857	1,727,580		1,727,580	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	108,569						1
2	Cap Rel Costs-Mvble Equip		108,569					2
4	Employee Benefits Department			14,042,706				4
5	Administrative & General	19,674	19,674	1,518,545	-3,737,090	24,217,410		5
6	Maintenance & Repairs	2,832	2,832	332,930		701,293	86,063	6
7	Operation of Plant	1,851	1,851			652,460	1,851	7
8	Laundry & Linen Service	1,279	1,279			430,135	1,279	8
9	Housekeeping	177	177	364,358		592,246	177	9
10	Dietary	131	131	150,693		316,138	131	10
11	Cafeteria	3,849	3,849	230,007		337,917	3,849	11
12	Maintenance of Personnel							12
13	Nursing Administration	128	128	272,821		356,338	128	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,473	1,473	280,601		502,840	1,473	16
17	Social Service	160	160	120,554		155,233	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	1,208,333		1,766,866	14,599	30
31	Intensive Care Unit	1,333	1,333	150,876		212,527	1,333	31
44	Skilled Nursing Facility	8,553	8,553	799,878		1,183,049	8,553	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,492	6,492	1,151,842		1,418,512	6,492	50
54	Radiology-Diagnostic	4,578	4,578	572,920		1,806,195	4,578	54
60	Laboratory	2,268	2,268	837,989		2,215,415	2,268	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,684	1,684	150,019		312,255	1,684	65
66	Physical Therapy	3,739	3,739	880,218		1,155,397	3,739	66
69	Electrocardiology			38,429		47,266		69
71	Medical Supplies Charged to Patients	1,776	1,776	55,401		558,409	1,776	71
72	Impl. Dev. Charged to Patients					121,083		72
73	Drugs Charged to Patients	2,728	2,728	240,965		1,739,836	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	18,068	18,068	2,445,545		3,667,708	18,068	88
90	Clinic	1,735	1,735	339,303		575,724	1,735	90
90.01	WOUND CARE							90.01
90.02	CLINIC	1,085	1,085	134,483		228,089	1,085	90.02
90.03	URGENT CARE	2,170	2,170	529,277		700,740	2,170	90.03
90.04	CISNE CLINIC							90.04
91	Emergency	2,322	2,322	733,391		1,608,912	2,322	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,920	1,920	358,841		567,450	1,920	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	106,604	106,604	13,898,219	-3,737,090	23,930,033	84,098	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices	1,965	1,965	144,487		287,377	1,965	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,209,676	517,904	3,229,253		3,737,090	809,512	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.142002	4.770275	0.229959		0.154314	9.406040	203
204	Cost to be allocated (Per Wkst. B, Part II)					313,058	54,129	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.012927	0.628946	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	84,212						7
8	Laundry & Linen Service	1,279	55,938					8
9	Housekeeping	177	12,445	77,654				9
10	Dietary	131	104	131	61,060			10
11	Cafeteria	3,849		3,849		387,473		11
12	Maintenance of Personnel							12
13	Nursing Administration	128		128		8,602	151,803	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,473		1,473		17,471		16
17	Social Service	160		160		6,006		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	15,505	14,599	13,397	50,422	50,422	30
31	Intensive Care Unit	1,333	41	1,333	2,278	5,039	5,039	31
44	Skilled Nursing Facility	8,553	9,256	8,553	45,385	41,341	41,341	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,492	252	6,492		26,317	26,317	50
54	Radiology-Diagnostic	4,578	4,524	4,578		22,722		54
60	Laboratory	2,268	783	2,268		41,786		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,684	843	1,684		8,410		65
66	Physical Therapy	3,739	1,320	3,739		26,265		66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	1,776		1,776		4,133		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	2,728		2,728		7,061		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	18,068	608	14,931		63,137		88
90	Clinic	1,735		1,735		9,846		90
90.01	WOUND CARE							90.01
90.02	CLINIC	1,085		1,085		4,867		90.02
90.03	URGENT CARE	2,170	95	2,170		15,364		90.03
90.04	CISNE CLINIC							90.04
91	Emergency	2,322	9,978	2,322		28,684	28,684	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,920		1,920				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	82,247	55,754	77,654	61,060	387,473	151,803	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices	1,965	184					192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	770,555	520,244	802,666	369,675	501,270	426,152	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.150180	9.300368	10.336441	6.054291	1.293690	2.807270	203
204	Cost to be allocated (Per Wkst. B, Part II)	39,052	27,309	16,741	6,394	70,651	8,379	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.463734	0.488201	0.215585	0.104717	0.182338	0.055197	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	85,968,473						16
17	Social Service		6,440					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	5,448,813	1,876					30
31	Intensive Care Unit	373,074						31
44	Skilled Nursing Facility	1,248,915	1,189					44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,259,443						50
54	Radiology-Diagnostic	20,029,091						54
60	Laboratory	14,347,097						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,303,230						65
66	Physical Therapy	3,910,187						66
69	Electrocardiology	1,382,046						69
71	Medical Supplies Charged to Patients	5,057,218						71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	7,163,251						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	4,367,040						88
90	Clinic	1,305,432						90
90.01	WOUND CARE							90.01
90.02	CLINIC	128,326						90.02
90.03	URGENT CARE	866,614						90.03
90.04	CISNE CLINIC							90.04
91	Emergency	3,778,696	3,375					91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	85,968,473	6,440					118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
192	Physicians' Private Offices							192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	645,596	191,581					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.007510	29.748602					203
204	Cost to be allocated (Per Wkst. B, Part II)	35,052	5,857					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000408	0.909472					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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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,990,141		2,990,141		2,990,141	30
31	Intensive Care Unit	321,476		321,476		321,476	31
44	Skilled Nursing Facility	2,187,874		2,187,874		2,187,874	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,027,316		2,027,316		2,027,316	50
54	Radiology-Diagnostic	2,439,048		2,439,048		2,439,048	54
60	Laboratory	2,791,901		2,791,901		2,791,901	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	460,133		460,133		460,133	65
66	Physical Therapy	1,517,342		1,517,342		1,517,342	66
69	Electrocardiology	64,939		64,939		64,939	69
71	Medical Supplies Charged to Patients	739,220		739,220		739,220	71
72	Impl. Dev. Charged to Patients	139,768		139,768		139,768	72
73	Drugs Charged to Patients	2,150,068		2,150,068		2,150,068	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	4,843,427		4,843,427		4,843,427	88
90	Clinic	737,237		737,237		737,237	90
90.01	WOUND CARE						90.01
90.02	CLINIC	301,895		301,895		301,895	90.02
90.03	URGENT CARE	898,839		898,839		898,839	90.03
90.04	CISNE CLINIC						90.04
91	Emergency	2,263,490		2,263,490		2,263,490	91
92	Observation Beds (Non-Distinct Part)	1,095,951		1,095,951		1,095,951	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	710,489		710,489		710,489	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	28,680,554		28,680,554		28,680,554	200
201	Less Observation Beds	1,095,951		1,095,951		1,095,951	201
202	Total (line 200 minus line 201)	27,584,603		27,584,603		27,584,603	202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	4,218,629		4,218,629				30
31	Intensive Care Unit	373,074		373,074				31
44	Skilled Nursing Facility	1,248,915		1,248,915				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,195,673	11,063,770	12,259,443	0.165368	0.165368	0.165368	50
54	Radiology-Diagnostic	865,866	19,163,225	20,029,091	0.121775	0.121775	0.121775	54
60	Laboratory	1,078,325	13,268,772	14,347,097	0.194597	0.194597	0.194597	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,989,234	2,313,996	4,303,230	0.106927	0.106927	0.106927	65
66	Physical Therapy	1,280,196	2,629,991	3,910,187	0.388048	0.388048	0.388048	66
69	Electrocardiology	170,729	1,211,317	1,382,046	0.046988	0.046988	0.046988	69
71	Medical Supplies Charged to Patients	976,233	3,928,127	4,904,360	0.150727	0.150727	0.150727	71
72	Impl. Dev. Charged to Patients	7,068	145,790	152,858	0.914365	0.914365	0.914365	72
73	Drugs Charged to Patients	1,744,545	5,418,706	7,163,251	0.300153	0.300153	0.300153	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		4,180,792	4,180,792				88
90	Clinic		1,305,432	1,305,432	0.564746	0.564746	0.564746	90
90.01	WOUND CARE							90.01
90.02	CLINIC		128,326	128,326	2.352563	2.352563	2.352563	90.02
90.03	URGENT CARE		866,614	866,614	1.037185	1.037185	1.037185	90.03
90.04	CISNE CLINIC							90.04
91	Emergency	72,765	3,705,931	3,778,696	0.599014	0.599014	0.599014	91
92	Observation Beds (Non-Distinct Part)	146,706	1,083,478	1,230,184	0.890884	0.890884	0.890884	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		698,528	698,528				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	15,367,958	71,112,795	86,480,753				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	15,367,958	71,112,795	86,480,753				202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (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	2,990,141		2,990,141		2,990,141	30
31	Intensive Care Unit	321,476		321,476		321,476	31
44	Skilled Nursing Facility	2,187,874		2,187,874		2,187,874	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,027,316		2,027,316		2,027,316	50
54	Radiology-Diagnostic	2,439,048		2,439,048		2,439,048	54
60	Laboratory	2,791,901		2,791,901		2,791,901	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	460,133		460,133		460,133	65
66	Physical Therapy	1,517,342		1,517,342		1,517,342	66
69	Electrocardiology	64,939		64,939		64,939	69
71	Medical Supplies Charged to Patients	739,220		739,220		739,220	71
72	Impl. Dev. Charged to Patients	139,768		139,768		139,768	72
73	Drugs Charged to Patients	2,150,068		2,150,068		2,150,068	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	4,843,427		4,843,427		4,843,427	88
90	Clinic	737,237		737,237		737,237	90
90.01	WOUND CARE						90.01
90.02	CLINIC	301,895		301,895		301,895	90.02
90.03	URGENT CARE	898,839		898,839		898,839	90.03
90.04	CISNE CLINIC						90.04
91	Emergency	2,263,490		2,263,490		2,263,490	91
92	Observation Beds (Non-Distinct Part)	1,095,951		1,095,951		1,095,951	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	710,489		710,489		710,489	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	28,680,554		28,680,554		28,680,554	200
201	Less Observation Beds	1,095,951		1,095,951		1,095,951	201
202	Total (line 200 minus line 201)	27,584,603		27,584,603		27,584,603	202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

		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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ 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	2,027,316	141,511	1,885,805		50
54	Radiology-Diagnostic	2,439,048	116,683	2,322,365		54
60	Laboratory	2,791,901	81,550	2,710,351		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	460,133	36,737	423,396		65
66	Physical Therapy	1,517,342	86,352	1,430,990		66
69	Electrocardiology	64,939	1,175	63,764		69
71	Medical Supplies Charged to Patients	739,220	40,620	698,600		71
72	Impl. Dev. Charged to Patients	139,768	1,565	138,203		72
73	Drugs Charged to Patients	2,150,068	73,678	2,076,390		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	4,843,427	371,472	4,471,955		88
90	Clinic	737,237	39,647	697,590		90
90.01	WOUND CARE					90.01
90.02	CLINIC	301,895	22,572	279,323		90.02
90.03	URGENT CARE	898,839	49,627	849,212		90.03
90.04	CISNE CLINIC					90.04
91	Emergency	2,263,490	77,081	2,186,409		91
92	Observation Beds (Non-Distinct Part)	1,095,951	109,633	986,318		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	710,489	40,399	670,090		101
113	Interest Expense					113
200	Subtotal	23,181,063	1,290,302	21,890,761		200
201	Less Observation Beds	1,095,951	109,633	986,318		201
202	Total	22,085,112	1,180,669	20,904,443		202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		2,027,316			50
54	Radiology-Diagnostic		2,439,048			54
60	Laboratory		2,791,901			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		460,133			65
66	Physical Therapy		1,517,342			66
69	Electrocardiology		64,939			69
71	Medical Supplies Charged to Patients		739,220			71
72	Impl. Dev. Charged to Patients		139,768			72
73	Drugs Charged to Patients		2,150,068			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		4,843,427			88
90	Clinic		737,237			90
90.01	WOUND CARE					90.01
90.02	CLINIC		301,895			90.02
90.03	URGENT CARE		898,839			90.03
90.04	CISNE CLINIC					90.04
91	Emergency		2,263,490			91
92	Observation Beds (Non-Distinct Part)		1,095,951	1,230,184	0.890884	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		710,489			101
113	Interest Expense					113
200	Subtotal		23,181,063	1,230,184		200
201	Less Observation Beds		1,095,951	1,230,184		201
202	Total		22,085,112			202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	0.165368		4,004,682			662,246		50
54	Radiology-Diagnostic	0.121775		8,933,934			1,087,930		54
60	Laboratory	0.194597		5,612,711			1,092,217		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.106927		1,045,932			111,838		65
66	Physical Therapy	0.388048		863,219			334,970		66
69	Electrocardiology	0.046988		563,645			26,485		69
71	Medical Supplies Charged to Pat	0.150727		1,517,667			228,753		71
72	Impl. Dev. Charged to Patients	0.914365		144,570			132,190		72
73	Drugs Charged to Patients	0.300153		3,070,391			921,587		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	0.564746		1,255,159			708,846		90
90.01	WOUND CARE								90.01
90.02	CLINIC	2.352563		70,983			166,992		90.02
90.03	URGENT CARE	1.037185		4,106			4,259		90.03
90.04	CISNE CLINIC								90.04
91	Emergency	0.599014		1,332,403			798,128		91
92	Observation Beds (Non-Distinct	0.890884		580,486			517,146		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			28,999,888			6,793,587		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			28,999,888			6,793,587		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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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 ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☒ SNF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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

		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	12,259,443							50
54	Radiology-Diagnostic	20,029,091			40,432				54
60	Laboratory	14,347,097			63,546				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,303,230			459,327				65
66	Physical Therapy	3,910,187			985,697				66
69	Electrocardiology	1,382,046			3,193				69
71	Medical Supplies Charged to Pat	4,904,360			259,407				71
72	Impl. Dev. Charged to Patients	152,858							72
73	Drugs Charged to Patients	7,163,251			360,935				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	4,180,792							88
90	Clinic	1,305,432							90
90.01	WOUND CARE								90.01
90.02	CLINIC	128,326							90.02
90.03	URGENT CARE	866,614							90.03
90.04	CISNE CLINIC								90.04
91	Emergency	3,778,696							91
92	Observation Beds (Non-Distinct	1,230,184							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	79,941,607			2,172,537				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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5552

WORKSHEET D PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.165368							50
54	Radiology-Diagnostic	0.121775							54
60	Laboratory	0.194597							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.106927							65
66	Physical Therapy	0.388048							66
69	Electrocardiology	0.046988							69
71	Medical Supplies Charged to Pat	0.150727							71
72	Impl. Dev. Charged to Patients	0.914365							72
73	Drugs Charged to Patients	0.300153							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	0.564746							90
90.01	WOUND CARE								90.01
90.02	CLINIC	2.352563							90.02
90.03	URGENT CARE	1.037185							90.03
90.04	CISNE CLINIC								90.04
91	Emergency	0.599014							91
92	Observation Beds (Non-Distinct	0.890884							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V
Applicable [] Title XVIII, Part A
Boxes: [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)	299,120		299,120	2,300	130.05	195	25,360	30
31	Intensive Care Unit	27,309		27,309	221	123.57	42	5,190	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	183,262		183,262	7,327	25.01			44
45	Nursing Facility								45
200	Total (lines 30-199)	509,691		509,691	9,848		237	30,550	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	141,511	12,259,443	0.011543			50
54	Radiology-Diagnostic	116,683	20,029,091	0.005826			54
60	Laboratory	81,550	14,347,097	0.005684			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	36,737	4,303,230	0.008537			65
66	Physical Therapy	86,352	3,910,187	0.022084			66
69	Electrocardiology	1,175	1,382,046	0.000850			69
71	Medical Supplies Charged to Pat	40,620	4,904,360	0.008282			71
72	Impl. Dev. Charged to Patients	1,565	152,858	0.010238			72
73	Drugs Charged to Patients	73,678	7,163,251	0.010286			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	371,472	4,180,792	0.088852			88
90	Clinic	39,647	1,305,432	0.030371			90
90.01	WOUND CARE						90.01
90.02	CLINIC	22,572	128,326	0.175896			90.02
90.03	URGENT CARE	49,627	866,614	0.057265			90.03
90.04	CISNE CLINIC						90.04
91	Emergency	77,081	3,778,696	0.020399			91
92	Observation Beds (Non-Distinct	109,633	1,230,184	0.089119			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,249,903	79,941,607				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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ TEFRA
Boxes: ☒ Title XIX ☒ 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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,300		195		30
31	Intensive Care Unit	221		42		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	7,327				44
45	Nursing Facility					45
200	Total (lines 30-199)	9,848		237		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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1311

WORKSHEET D PART IV

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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								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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)	2,300	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,300	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)	1,457	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)	955	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)	2,990,141	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)	2,990,141	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)	2,990,141	37

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)					1,300.06	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,241,557	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)					1,241,557	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	321,476	221	1,454.64	126	183,285	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)					859,354	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,284,196	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)					843	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,300.06	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,095,951	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	299,120	2,990,141	0.100035	1,095,951	109,633	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)	7,327	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,327	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)	7,327	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)	1,637	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)	2,187,874	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)	2,187,874	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,187,874	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)	2,187,874	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	298.60	71
72	Program routine service cost (line 9 x line 71)	488,808	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)	488,808	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)	488,808	83
84	Program inpatient ancillary services (see instructions)	596,488	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	1,085,296	86

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)	2,300	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,300	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)	1,457	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)	195	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)	2,990,141	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)	2,990,141	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,990,141	37

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)						1,300.06	38
39	Program general inpatient routine service cost (line 9 x line 38)						253,512	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)						253,512	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	321,476	221	1,454.64	42	61,095		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)						314,607	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						30,550	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)						30,550	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)					843	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,300.06	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,095,951	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	299,120	2,990,141	0.100035	1,095,951	109,633	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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		1,179,425		30
31	Intensive Care Unit		256,788		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.165368	491,840	81,335	50
54	Radiology-Diagnostic	0.121775	665,442	81,034	54
60	Laboratory	0.194597	761,521	148,190	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.106927	873,497	93,400	65
66	Physical Therapy	0.388048	128,080	49,701	66
69	Electrocardiology	0.046988	84,378	3,965	69
71	Medical Supplies Charged to Patients	0.150727	715,846	107,897	71
72	Impl. Dev. Charged to Patients	0.914365	7,068	6,463	72
73	Drugs Charged to Patients	0.300153	797,129	239,261	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	0.564746			90
90.01	WOUND CARE				90.01
90.02	CLINIC	2.352563			90.02
90.03	URGENT CARE	1.037185			90.03
90.04	CISNE CLINIC				90.04
91	Emergency	0.599014	41,496	24,857	91
92	Observation Beds (Non-Distinct Part)	0.890884	26,099	23,251	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,592,396	859,354	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,592,396		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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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 [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [XX] 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	0.165368			50
54	Radiology-Diagnostic	0.121775	40,432	4,924	54
60	Laboratory	0.194597	63,546	12,366	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.106927	459,327	49,114	65
66	Physical Therapy	0.388048	985,697	382,498	66
69	Electrocardiology	0.046988	3,193	150	69
71	Medical Supplies Charged to Patients	0.150727	259,407	39,100	71
72	Impl. Dev. Charged to Patients	0.914365			72
73	Drugs Charged to Patients	0.300153	360,935	108,336	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	0.564746			90
90.01	WOUND CARE				90.01
90.02	CLINIC	2.352563			90.02
90.03	URGENT CARE	1.037185			90.03
90.04	CISNE CLINIC				90.04
91	Emergency	0.599014			91
92	Observation Beds (Non-Distinct Part)	0.890884			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,172,537	596,488	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,172,537		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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)	6,793,587			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)	6,793,587			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)	6,861,523			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)	101,582			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,621,322			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)	2,138,619			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)	2,138,619			30
31	Primary payer payments	17			31
32	Subtotal (line 30 minus line 31)	2,138,602			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	1,207,567			34
35	Adjusted reimbursable bad debts (see instructions)	784,919			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	17,673			36
37	Subtotal (see instructions)	2,923,521			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)	2,923,521			40
40.01	Sequestration adjustment (see instructions)	58,470			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,947,526			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-82,475			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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COMPONENT CCN: 14-1311

WORKSHEET E-1
PART I

Check	[XX]	Hospital	[]	SUB (Other)
Applicable	[]	IPF	[]	SNF
Boxes:	[]	IRF	[]	Swing Bed SNF

				INPATIENT PART A		PART B		
DESCRIPTION				mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider				1,722,427		2,900,926	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	02/13/2019	187,300	02/13/2019	46,600	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		187,300		46,600	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)				1,909,727		2,947,526	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					5.01
			.02					5.02
		Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01		27,246			6.01
			.02				-82,475	6.02
7	Total Medicare program liability (see instructions)				1,936,973		2,865,051	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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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	2,284,196	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,284,196	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,307,038	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)	2,307,038	19
20	Deductibles (exclude professional component)	376,138	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,930,900	22
23	Coinsurance	6,431	23
24	Subtotal (line 22 minus line 23)	1,924,469	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	80,053	25
26	Adjusted reimbursable bad debts (see instructions)	52,034	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,564	27
28	Subtotal (sum of lines 24 and 26)	1,976,503	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,976,503	30
30.01	Sequestration adjustment (see instructions)	39,530	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	1,909,727	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)	27,246	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	Coinurance		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	314,607		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	314,607		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	314,607		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)	314,607		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)	314,607		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)	314,607		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)	314,607		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	314,607		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)	314,607		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	314,607		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	298,667				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,907,971				4
5	Other receivables	1,107,571				5
6	Allowances for uncollectible notes and accounts receivable	-2,950,164				6
7	Inventory	582,776				7
8	Prepaid expenses	583,853				8
9	Other current assets	302,973				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	6,833,647				11
	FIXED ASSETS					
12	Land	449,428				12
13	Land improvements	657,953				13
14	Accumulated depreciation	-623,483				14
15	Buildings	24,403,143				15
16	Accumulated depreciation	-14,236,005				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	1,982,406				19
20	Accumulated depreciation	-1,398,026				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,880,252				23
24	Accumulated depreciation	-10,312,036				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)	12,803,632				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,830,627				34
35	Total other assets (sum of lines 31-34)	4,830,627				35
36	Total assets (sum of lines 11, 30 and 35)	24,467,906				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	755,261				37
38	Salaries, wages and fees payable	1,128,095				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	552,571				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	2,435,927				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	5,276,501				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	5,276,501				50
51	Total liabilities (sum of lines 45 and 50)	7,712,428				51
	CAPITAL ACCOUNTS					
52	General fund balance	16,755,478				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)	16,755,478				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	24,467,906				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		16,050,573		1
2	Net income (loss) (from Worksheet G-3, line 29)		704,905		2
3	Total (sum of line 1 and line 2)		16,755,478		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)		16,755,478		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)		16,755,478		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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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	4,218,629		4,218,629	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,248,915		1,248,915	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	5,467,544		5,467,544	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	373,074		373,074	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)	373,074		373,074	16
17	Total inpatient routine care services (sum of lines 10 and 16)	5,840,618		5,840,618	17
18	Ancillary services	9,307,869	59,143,694	68,451,563	18
19	Outpatient services	219,471	7,089,781	7,309,252	19
20	Rural Health Clinic (RHC)		4,180,792	4,180,792	20
20.01	RHC II				20.01
20.02	RHC III				20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		698,528	698,528	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PRO FEES	311,620	6,044,243	6,355,863	27
27.01	NON-REIMBURSABLE RHC BEFORE CERTIFIED		186,248	186,248	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	15,679,578	77,343,286	93,022,864	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		32,031,979	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)		32,031,979	43

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	93,022,864	1
2	Less contractual allowances and discounts on patients' accounts	61,562,504	2
3	Net patient revenues (line 1 minus line 2)	31,460,360	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	32,031,979	4
5	Net income from service to patients (line 3 minus line 4)	-571,619	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	34,952	6
7	Income from investments	100,076	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	202,680	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	14,280	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	244,797	22
23	Governmental appropriations		23
24	Other (MISCELLANEOUS)	155,744	24
24.01	Other (GRANTS)		24.01
24.02	Other (DEFERRED REVENUE)	165,747	24.02
24.03	Other (REBATES)	5,978	24.03
24.04	Other (EHR INCENTIVE)		24.04
24.05	Other (SALE OF SCRAP)		24.05
24.06	Other (340B)	352,270	24.06
25	Total other income (sum of lines 6-24)	1,276,524	25
26	Total (line 5 plus line 25)	704,905	26
29	Net income (or loss) for the period (line 26 minus line 28)	704,905	29

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	41,990		55,414	10,176	29,948	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	225,658					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	91,193					23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	358,841		55,414	10,176	29,948	24

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS**HHa 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	137,528		137,528		137,528	5
	HHa REIMBURSABLE SERVICES						
6	Skilled Nursing Care	225,658		225,658		225,658	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	91,193		91,193		91,193	23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	454,379		454,379		454,379	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	137,528				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	225,658				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	91,193				23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	454,379				24

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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		137,528	137,528		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		225,658	97,946	323,604	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		91,193	39,582	130,775	23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		454,379		454,379	24

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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					-137,528	316,851	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						225,658	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						91,193	23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-137,528	316,851	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						137,528	25
26	Unit Cost Multiplier						0.434046	26

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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		21,393	9,159	9,656	40,208	6,205	1
2	Skilled Nursing Care	323,604			51,892	375,496	57,944	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	130,775			20,971	151,746	23,416	19
20	Totals (sum of lines 1-19)(2)	454,379	21,393	9,159	82,519	567,450	87,565	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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	18,060	17,568		19,846			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)	18,060	17,568		19,846			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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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						101,887	1
2	Skilled Nursing Care						433,440	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						175,162	19
20	Totals (sum of lines 1-19)(2)						710,489	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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		101,887					1
2	Skilled Nursing Care		433,440	72,563	506,003			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		175,162	29,324	204,486			19
20	Totals (sum of lines 1-19)(2)		710,489	101,887	710,489			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.			0.167412				21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

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FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	41,990		40,208	1,920	1
2	Skilled Nursing Care			225,658		375,496		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			91,193		151,746		19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	1,920	1,920	358,841		567,450	1,920	20
21	Total cost to be allocated	21,393	9,159	82,519		87,565	18,060	21
22	Unit Cost Multiplier	11.142188		0.229960		0.154313		22
22	Unit Cost Multiplier		4.770313				9.406250	22

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	17,568		19,846				21
22	Unit Cost Multiplier	9.150000		10.336458				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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	506,003		506,003	2,774	182.41	1
2	Physical Therapy	3				1,390		2
3	Occupational Therapy	4				288		3
4	Speech Pathology	5				77		4
5	Medical Social Services	6						5
6	Home Health Aide	7				246		6
7	Total (sum of lines 1-6)		506,003		506,003	4,775		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		1,912			8
9	Physical Therapy		14999		1,078			9
10	Occupational Therapy		14999		250			10
11	Speech Pathology		14999		48			11
12	Medical Social Services		14999					12
13	Home Health Aide		14999		1			13
14	Total (sum of lines 8-13)				3,289			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	0.388048			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	0.150727			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.300153			col. 2, line 16	5

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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		1,912			348,768		348,768	1
2	Physical Therapy		1,078						2
3	Occupational Therapy		250						3
4	Speech Pathology		48						4
5	Medical Social Services								5
6	Home Health Aide		1						6
7	Total (sum of lines 1-6)		3,289			348,768		348,768	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

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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		452,838	11
12	Total PPS Reimbursement - Full Episodes with Outliers		59,361	12
13	Total PPS Reimbursement - LUPA Episodes		8,602	13
14	Total PPS Reimbursement - PEP Episodes		3,100	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		24,860	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)		548,761	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		548,761	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		548,761	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)		548,761	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		548,761	31
31.01	Sequestration adjustment (see instructions)		10,975	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		537,785	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

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM HHA CCN: 14-7612
BENEFICIARIES

WORKSHEET H-5

				Part A		Part B		
	DESCRIPTION			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider						537,785	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)						537,785	4
	(transfer to Wkst. H-4, Part II, column as appropriate, line 32)							
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)		.01				1	6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						537,786	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.

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES
**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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
192	Physicians' Private Offices							192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	988,624		988,624	80,950	1,069,574	-71,305	998,269	1
2	Physician Assistant	444,422		444,422		444,422		444,422	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker	147,095		147,095		147,095		147,095	7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	1,580,141		1,580,141	80,950	1,661,091	-71,305	1,589,786	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)	1,580,141		1,580,141	80,950	1,661,091	-71,305	1,589,786	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	928,941	515,729	1,444,670	-216,634	1,228,036		1,228,036	30
31	Total Facility Overhead (sum of lines 29 and 30)	928,941	515,729	1,444,670	-216,634	1,228,036		1,228,036	31
32	Total facility costs (sum of lines 22, 28 and 31)	2,509,082	515,729	3,024,811	-135,684	2,889,127	-71,305	2,817,822	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.

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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	3.45	13,254	4,200	14,490		1
2	Physician Assistants	3.65	11,102	2,100	7,665		2
3	Nurse Practitioners			2,100			3
4	Subtotal (sum of lines 1 through 3)	7.10	24,356		22,155	24,356	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker	1.93	6,334			6,334	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)	9.03	30,690			30,690	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)	1,589,786	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)	1,589,786	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)	1,228,036	14
15	Parent provider overhead allocated to facility (see instructions)	2,025,605	15
16	Total overhead (sum of lines 14 and 15)	3,253,641	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	3,253,641	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	3,253,641	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	4,843,427	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.

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)	4,843,427	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	131,083	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	4,712,344	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	30,690	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	30,690	6
7	Adjusted cost per visit (line 3 divided by line 6)	153.55	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)	153.55	153.55	153.55	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		6,658		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,022,336		11
12	Program covered visits for mental health services (from contractor records)		268		12
13	Program covered cost from mental health services (line 9 x line 12)		41,151		13
14	Limit adjustment for mental health services (see instructions)		41,151		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,063,487		16
16.01	Total program charges (see instructions)(from contractor's records)		847,210		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		57,424		16.02
16.03	Total program preventive costs (see instructions)		72,083		16.03
16.04	Total program non-preventive costs (see instructions)		710,277		16.04
16.05	Total program cost (see instructions)		782,360		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		103,558		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		148,730		19
20	Net Medicare cost excluding vaccines (see instructions)		782,360		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		98,116		21
22	Total reimbursable Program cost (line 20 plus line 21)		880,476		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)		880,476		26
26.01	Sequestration adjustment (see instructions)		17,610		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		788,513		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		74,353		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: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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)	1,589,786	1,589,786	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002000	0.004184	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,180	6,652	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	22,408	10,787	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	25,588	17,439	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,589,786	1,589,786	6
7	Total overhead (from Wkst. M-2, line 16)	3,253,641	3,253,641	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016095	0.010969	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	52,367	35,689	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	77,955	53,128	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	206	431	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	378.42	123.27	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	171	271	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	64,710	33,406	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)		131,083	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)		98,116	16

KPMG LLP Compu-Max 2552-10

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:35 Version: 2018.12 (10/21/2019)
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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			788,513	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)			788,513	
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		74,353	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			862,866	
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.