FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/22/2017 Time: 08:19 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [ ] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 07/01/2016 and ending 06/30/2017, 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.

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		201,780	-581,461	1	3,142,685	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			-2,589			9
10	HEALTH CLINIC - RHC			-1,520			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		201,780	-585,570	1	3,142,685	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 resopnd 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 appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	FAIRFIELD MEMORIAL HOSPITAL	14-1311	14999	1	04 / 01 / 2001	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	14-5552	14999		03 / 26 / 1985	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	14-7612	14999		05 / 01 / 1995	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	14-8500	14999		03 / 13 / 2009	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	2	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
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	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	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	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 ad 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
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the 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 osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived 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 64-67. (see instructions)	N			63

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 oolumn 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 Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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 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 a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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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

Rural Providers				1	2	
105	Does this hospital qualify as a critical access hospital (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 elinination 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
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	324,161	5,012		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 or similar taxes? 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, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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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 on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:		Contractor's Number:		141
142	Street:	P.O. Box:				142
143	City:	State:	ZIP Code:			143
144	Are provider based physicians' costs included in Worksheet A?			Y		144
145	If costs for renal services are claimed on 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 / 2016	06 / 30 / 2017	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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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 instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2017	Y	11/08/2017	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 Reoprt 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	40,872.00		1,125	167	1,703	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	40,872.00		1,125	167	1,703	7
8	Intensive Care Unit	31	4	1,460	6,072.00		126	45	253	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	46,944.00		1,251	212	1,956	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			1,780		7,545	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,501	273	3,466	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					6,195	9,406	25,993	26
27	Total (sum of lines 14-26)		55							27
28	Observation Bed Days								755	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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					418	67	605	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)		212.03			418	67	605	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		19.50						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		13.71						26
27	Total (sum of lines 14-26)		245.24						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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

HOME HEALTH AGENCY STATISTICAL DATA County: WAYNE

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours						1
2	Unduplicated Census Count (see instructions)		133.00		41.00	174.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	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					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	1,505	140	42	49	1,736	21
22	Skilled Nursing Visit Charges	158,400	14,960	4,400	5,060	182,820	22
23	Physical Therapy Visits	532	18	2	12	564	23
24	Physical Therapy Visit Charges	57,530	1,980	110	990	60,610	24
25	Occupational Therapy Visits	171		4	3	178	25
26	Occupational Therapy Visit Charges	18,700		330	220	19,250	26
27	Speech Pathology Visits	19				19	27
28	Speech Pathology Visit Charges	2,185				2,185	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits	4				4	31
32	Home Health Aide Visit Charges	248				248	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,231	158	48	64	2,501	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	237,063	16,940	4,840	6,270	265,113	35
36	Total Number of Episodes (standard/non-outlier)						36
37	Total Number of Ourlier Episodes		4			4	37
38	Total Non-Routine Medical Supply Charges	45,830	1,893	1,545	1,588	50,856	38

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	8		8	6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	102		102	12
13	RUB	7		7	13
14	RUA	82		82	14
15	RVC	262		262	15
16	RVB	408		408	16
17	RVA	454		454	17
18	RHC	84		84	18
19	RHB	109		109	19
20	RHA	112		112	20
21	RMC	9		9	21
22	RMB	1		1	22
23	RMA	29		29	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	6		6	28
29	HE2	7		7	29
30	HE1				30
31	HD2				31
32	HD1	18		18	32
33	HC2	12		12	33
34	HC1	2		2	34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1	5		5	38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1	15		15	46
47	CD2				47
48	CD1	7		7	48
49	CC2				49
50	CC1	27		27	50
51	CB2				51
52	CB1	11		11	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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL	1,780		1,780	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 catetory. 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)	1,154,918			207

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-8500** **WORKSHEET S-8**

Check applicable box: **[XX] 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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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)	0.311617	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,287,499	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	3,881,947	5
6	Medicaid charges	18,073,621	6
7	Medicaid cost (line 1 times line 6)	5,632,048	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.	462,602	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	462,602	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)	249,047		249,047	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	77,607		77,607	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)	77,607		77,607	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)	1,980,220	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	599,416	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	922,178	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	1,058,042	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	652,466	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	730,073	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,192,675	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		1,440,368	1,440,368	276,952	1,717,320	-444,360	1,272,960	1
2	00200	Cap Rel Costs-Mvble Equip		662,768	662,768		662,768		662,768	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		2,853,693	2,853,693		2,853,693		2,853,693	4
5	00500	Administrative & General	1,311,216	2,430,722	3,741,938		3,741,938	-951,732	2,790,206	5
6	00600	Maintenance & Repairs	308,302	271,340	579,642		579,642		579,642	6
7	00700	Operation of Plant		585,463	585,463		585,463		585,463	7
8	00800	Laundry & Linen Service		431,725	431,725		431,725		431,725	8
9	00900	Housekeeping	335,094	153,579	488,673		488,673		488,673	9
10	01000	Dietary	352,927	280,950	633,877	-389,147	244,730		244,730	10
11	01100	Cafeteria				389,147	389,147	-172,286	216,861	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	253,965	12,061	266,026		266,026		266,026	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	238,024	166,563	404,587		404,587	-11,457	393,130	16
17	01700	Social Service	81,401	6,672	88,073		88,073		88,073	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	1,160,570	209,281	1,369,851		1,369,851	-147,003	1,222,848	30
31	03100	Intensive Care Unit	172,567	3,692	176,259		176,259		176,259	31
44	04400	Skilled Nursing Facility	704,214	45,597	749,811		749,811		749,811	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,073,035	232,439	1,305,474		1,305,474	-407,167	898,307	50
54	05400	Radiology-Diagnostic	511,023	879,413	1,390,436		1,390,436		1,390,436	54
60	06000	Laboratory	745,651	1,082,601	1,828,252		1,828,252		1,828,252	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	161,234	139,929	301,163	-77,083	224,080		224,080	65
66	06600	Physical Therapy	651,516	26,898	678,414		678,414		678,414	66
69	06900	Electrocardiology				77,083	77,083	-39,515	37,568	69
71	07100	Medical Supplies Charged to Patients	51,540	421,752	473,292	-204,456	268,836		268,836	71
72	07200	Impl. Dev. Charged to Patients				204,456	204,456		204,456	72
73	07300	Drugs Charged to Patients	223,226	1,342,493	1,565,719		1,565,719	-58,350	1,507,369	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	2,065,592	278,465	2,344,057	72,568	2,416,625	-98,601	2,318,024	88
90	09000	Clinic	371,993	127,735	499,728	-72,568	427,160		427,160	90
90.01	09001	WOUND CARE		39,300	39,300		39,300		39,300	90.01
90.02	09002	CLINIC	69,033	129,611	198,644		198,644		198,644	90.02
90.03	09003	URGENT CARE	325,665	74,730	400,395		400,395		400,395	90.03
91	09100	Emergency	694,865	1,944,857	2,639,722		2,639,722	-1,220,498	1,419,224	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	260,159	58,211	318,370		318,370		318,370	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		334,443	334,443	-276,952	57,491	-57,491		113
118		SUBTOTALS (sum of lines 1-117)	12,122,812	16,667,351	28,790,163		28,790,163	-3,608,460	25,181,703	118
		NONREIMBURSABLE COST CENTERS								
190.01	19001	VENDING MACHINE								190.01
200		TOTAL (sum of lines 118-199)	12,122,812	16,667,351	28,790,163		28,790,163	-3,608,460	25,181,703	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA	A	Cafeteria	11	216,667	172,480	1
500	Total reclassifications				216,667	172,480	500
	Code Letter - A						
1	TO RECLASS EKG	B	Electrocardiology	69	37,568	39,515	1
500	Total reclassifications				37,568	39,515	500
	Code Letter - B						
1	TO RECLASS INTEREST	C	Cap Rel Costs-Bldg & Fixt	1		276,952	1
500	Total reclassifications					276,952	500
	Code Letter - C						
1	TO RECLASS IMPLANTABLE DEVICES	D	Impl. Dev. Charged to Patient	72		204,456	1
500	Total reclassifications					204,456	500
	Code Letter - D						
1	BAHAVIORAL HEALTH	E	Rural Health Clinic	88	69,660	2,908	1
500	Total reclassifications				69,660	2,908	500
	Code Letter - E						
	GRAND TOTAL (Increases)				323,895	696,311	

(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.

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	216,667	172,480		1
500	Total reclassifications				216,667	172,480		500
	Code letter - A							
1	TO RECLASS EKG	B	Respiratory Therapy	65	37,568	39,515		1
500	Total reclassifications				37,568	39,515		500
	Code letter - B							
1	TO RECLASS INTEREST	C	Interest Expense	113		276,952	11	1
500	Total reclassifications					276,952		500
	Code letter - C							
1	TO RECLASS IMPLANTABLE DEVICES	D	Medical Supplies Charged to P	71		204,456		1
500	Total reclassifications					204,456		500
	Code letter - D							
1	BAHAVIORAL HEALTH	E	Clinic	90	69,660	2,908		1
500	Total reclassifications				69,660	2,908		500
	Code letter - E							
	GRAND TOTAL (Decreases)				323,895	696,311		

(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.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	449,428					449,428		1
2	Land Improvements	640,428					640,428		2
3	Buildings and Fixtures	24,042,995	118,930		118,930		24,161,925		3
4	Building Improvements								4
5	Fixed Equipment	1,498,910					1,498,910		5
6	Movable Equipment	11,109,563	176,264		176,264		11,285,827		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	37,741,324	295,194		295,194		38,036,518		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	37,741,324	295,194		295,194		38,036,518		10

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

		SUMMARY OF CAPITAL							
	Description	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	1,440,368						1,440,368	1
2	Cap Rel Costs-Mvble Equip	662,768						662,768	2
3	Total (sum of lines 1-2)	2,103,136						2,103,136	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	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	1,440,368		1,440,368	0.684867					1
2	Cap Rel Costs-Mvble Equ	662,768		662,768	0.315133					2
3	Total (sum of lines 1-2)	2,103,136		2,103,136	1.000000					3

		SUMMARY OF CAPITAL							
	Description	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	996,008		276,952				1,272,960	1
2	Cap Rel Costs-Mvble Equip	662,768						662,768	2
3	Total (sum of lines 1-2)	1,658,776		276,952				1,935,728	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**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			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	-57,491	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	-2,376	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	-1,814,183				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-908	Administrative & General	5		11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-172,286	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	-11,457	Medical Records & Library	16		18
19	Nursing school (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	-176,708	Cap Rel Costs-Bldg & Fixt	1	9	32
33	VERIZON RENTAL	B	-91,630	Cap Rel Costs-Bldg & Fixt	1	9	33
33.01	RINARD & WEBER CLINIC	A	-13,522	Cap Rel Costs-Bldg & Fixt	1	9	33.01
33.02	RECRUITING	A	-117,228	Administrative & General	5		33.02
33.03	ADVERTISING	A	-152,501	Administrative & General	5		33.03
33.04	OTHER REVENUE	B	-2,745	Administrative & General	5		33.04
33.05	WAYFAIR RENTAL	B	-162,500	Cap Rel Costs-Bldg & Fixt	1	9	33.05
33.06	PROVIDER TAX	A	-666,390	Administrative & General	5		33.06
33.08	340B REVENUE	B	-58,350	Drugs Charged to Patients	73		33.08
34	HOSPITALIST IN RHC	A	-98,601	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	-9,584	Administrative & General	5		43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,608,460				50

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	54	Radiology-Diagnostic	MRI	195,829	195,829			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			195,829	195,829			5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	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	103,797	103,797						1
2	30	Adults & Pediatrics								2
3	30	Adults & Pediatrics AGGREGATE	43,206	43,206						3
4	30	Adults & Pediatrics								4
5	30	Adults & Pediatrics								5
6	50	Operating Room AGGREGATE	407,167	407,167						6
7	50	Operating Room								7
8	50	Operating Room								8
9	60	Laboratory								9
10	69	Electrocardiology AGGREGATE	32,235	32,235						10
11	69	Electrocardiology								11
12	69	Electrocardiology AGGREGATE	7,280	7,280						12
13	91	Emergency AGGREGATE	1,757,124	1,220,498	536,626					13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,350,809	1,814,183	536,626					200

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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							103,797	1
2	30	Adults & Pediatrics								2
3	30	Adults & Pediatrics AGGREGATE							43,206	3
4	30	Adults & Pediatrics								4
5	30	Adults & Pediatrics								5
6	50	Operating Room AGGREGATE							407,167	6
7	50	Operating Room								7
8	50	Operating Room								8
9	60	Laboratory								9
10	69	Electrocardiology AGGREGATE							32,235	10
11	69	Electrocardiology								11
12	69	Electrocardiology AGGREGATE							7,280	12
13	91	Emergency AGGREGATE							1,220,498	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,814,183	200

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	1,272,960	1,272,960					1
2	Cap Rel Costs-Mvble Equip	662,768		662,768				2
4	Employee Benefits Department	2,853,693			2,853,693			4
5	Administrative & General	2,790,206	242,051	126,023	308,659	3,466,939	3,466,939	5
6	Maintenance & Repairs	579,642	34,842	18,141	72,574	705,199	112,591	6
7	Operation of Plant	585,463	22,773	11,857		620,093	99,003	7
8	Laundry & Linen Service	431,725	15,736	8,193		455,654	72,749	8
9	Housekeeping	488,673	2,178	1,134	78,881	570,866	91,143	9
10	Dietary	244,730	1,612	839	32,075	279,256	44,585	10
11	Cafeteria	216,861	47,354	24,655	51,003	339,873	54,263	11
12	Maintenance of Personnel							12
13	Nursing Administration	266,026	1,575	820	59,783	328,204	52,400	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	393,130	18,122	9,435	56,031	476,718	76,112	16
17	Social Service	88,073	1,968	1,025	19,162	110,228	17,599	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	1,222,848	179,612	93,515	273,197	1,769,172	282,462	30
31	Intensive Care Unit	176,259	16,400	8,539	40,622	241,820	38,608	31
44	Skilled Nursing Facility	749,811	105,228	54,787	165,771	1,075,597	171,728	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	898,307	79,871	41,585	252,591	1,272,354	203,141	50
54	Radiology-Diagnostic	1,390,436	56,323	29,325	120,294	1,596,378	254,875	54
60	Laboratory	1,828,252	27,903	14,528	175,525	2,046,208	326,693	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	224,080	20,718	10,787	29,111	284,696	45,454	65
66	Physical Therapy	678,414	46,001	23,951	153,366	901,732	143,969	66
69	Electrocardiology	37,568			8,843	46,411	7,410	69
71	Medical Supplies Charged to Patients	268,836	21,850	11,376	12,132	314,194	50,164	71
72	Impl. Dev. Charged to Patients	204,456				204,456	32,643	72
73	Drugs Charged to Patients	1,507,369	33,563	17,474	52,547	1,610,953	257,202	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	2,318,024	183,697	95,642	502,634	3,099,997	494,942	88
90	Clinic	427,160	21,346	11,114	71,169	530,789	84,745	90
90.01	WOUND CARE	39,300				39,300	6,275	90.01
90.02	CLINIC	198,644	13,349	6,950	16,250	235,193	37,550	90.02
90.03	URGENT CARE	400,395	26,698	13,900	76,661	517,654	82,648	90.03
91	Emergency	1,419,224	28,568	14,874	163,571	1,626,237	259,642	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	318,370	23,622	12,299	61,241	415,532	66,343	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	25,181,703	1,272,960	662,768	2,853,693	25,181,703	3,466,939	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,181,703	1,272,960	662,768	2,853,693	25,181,703	3,466,939	202

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	817,790						6
7	Operation of Plant	18,697	737,793					7
8	Laundry & Linen Service	12,919	11,928	553,250				8
9	Housekeeping	1,788	1,651	70,440	735,888			9
10	Dietary	1,323	1,222	4,763	1,241	332,390		10
11	Cafeteria	38,879	35,896		36,475		505,386	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,293	1,194		1,213		9,865	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	14,879	13,737		13,959		25,132	16
17	Social Service	1,616	1,492		1,516		6,125	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	147,465	136,153	77,828	138,347	72,930	72,024	30
31	Intensive Care Unit	13,465	12,432	4,603	12,632	12,400	8,546	31
44	Skilled Nursing Facility	86,394	79,767	109,685	81,052	247,060	57,714	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	65,576	60,545	63,251	61,521		37,683	50
54	Radiology-Diagnostic	46,243	42,695	50,263	43,383		30,956	54
60	Laboratory	22,909	21,152	9,765	21,493		53,933	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	17,010	15,705	5,784	15,958		11,721	65
66	Physical Therapy	37,768	34,871	39,069	35,433		28,740	66
69	Electrocardiology			718				69
71	Medical Supplies Charged to Patients	17,939	16,563		16,830		5,738	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	27,556	25,442		25,852		9,496	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	150,818	139,249	7,691	141,496		73,544	88
90	Clinic	17,525	16,181		16,442		13,575	90
90.01	WOUND CARE							90.01
90.02	CLINIC	10,960	10,119	702	10,282		5,885	90.02
90.03	URGENT CARE	21,919	20,238	2,370	20,564		13,398	90.03
91	Emergency	23,455	21,655	106,318	22,004		41,311	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	19,394	17,906		18,195			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	817,790	737,793	553,250	735,888	332,390	505,386	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	817,790	737,793	553,250	735,888	332,390	505,386	202

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	394,169						13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		620,537					16
17	Social Service			138,576				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	133,805	38,398	73,992	2,942,576		2,942,576	30
31	Intensive Care Unit	15,876	2,744		363,126		363,126	31
44	Skilled Nursing Facility	107,220	8,926	26,673	2,051,816		2,051,816	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	70,007	120,869		1,954,947		1,954,947	50
54	Radiology-Diagnostic		134,966		2,199,759		2,199,759	54
60	Laboratory		91,143		2,593,296		2,593,296	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		36,270		432,598		432,598	65
66	Physical Therapy		24,307		1,245,889		1,245,889	66
69	Electrocardiology		8,902		63,441		63,441	69
71	Medical Supplies Charged to Patients		31,587		453,015		453,015	71
72	Impl. Dev. Charged to Patients		985		238,084		238,084	72
73	Drugs Charged to Patients		44,982		2,001,483		2,001,483	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		27,042		4,134,779		4,134,779	88
90	Clinic		9,142	37,911	726,310		726,310	90
90.01	WOUND CARE		982		46,557		46,557	90.01
90.02	CLINIC		2,972		313,663		313,663	90.02
90.03	URGENT CARE		6,035		684,826		684,826	90.03
91	Emergency	67,261	30,285		2,198,168		2,198,168	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency				537,370		537,370	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	394,169	620,537	138,576	25,181,703		25,181,703	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	394,169	620,537	138,576	25,181,703		25,181,703	202

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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		242,051	126,023	368,074	368,074		5
6	Maintenance & Repairs		34,842	18,141	52,983	11,953	64,936	6
7	Operation of Plant		22,773	11,857	34,630	10,511	1,485	7
8	Laundry & Linen Service		15,736	8,193	23,929	7,723	1,026	8
9	Housekeeping		2,178	1,134	3,312	9,676	142	9
10	Dietary		1,612	839	2,451	4,733	105	10
11	Cafeteria		47,354	24,655	72,009	5,761	3,087	11
12	Maintenance of Personnel							12
13	Nursing Administration		1,575	820	2,395	5,563	103	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		18,122	9,435	27,557	8,080	1,181	16
17	Social Service		1,968	1,025	2,993	1,868	128	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		179,612	93,515	273,127	29,987	11,709	30
31	Intensive Care Unit		16,400	8,539	24,939	4,099	1,069	31
44	Skilled Nursing Facility		105,228	54,787	160,015	18,231	6,860	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		79,871	41,585	121,456	21,566	5,207	50
54	Radiology-Diagnostic		56,323	29,325	85,648	27,059	3,672	54
60	Laboratory		27,903	14,528	42,431	34,683	1,819	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		20,718	10,787	31,505	4,826	1,351	65
66	Physical Therapy		46,001	23,951	69,952	15,284	2,999	66
69	Electrocardiology					787		69
71	Medical Supplies Charged to Patients		21,850	11,376	33,226	5,326	1,424	71
72	Impl. Dev. Charged to Patients					3,466		72
73	Drugs Charged to Patients		33,563	17,474	51,037	27,306	2,188	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		183,697	95,642	279,339	52,554	11,977	88
90	Clinic		21,346	11,114	32,460	8,997	1,392	90
90.01	WOUND CARE					666		90.01
90.02	CLINIC		13,349	6,950	20,299	3,987	870	90.02
90.03	URGENT CARE		26,698	13,900	40,598	8,774	1,740	90.03
91	Emergency		28,568	14,874	43,442	27,565	1,862	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		23,622	12,299	35,921	7,043	1,540	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,272,960	662,768	1,935,728	368,074	64,936	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,272,960	662,768	1,935,728	368,074	64,936	202

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	46,626						7
8	Laundry & Linen Service	754	33,432					8
9	Housekeeping	104	4,257	17,491				9
10	Dietary	77	288	30	7,684			10
11	Cafeteria	2,269		867		83,993		11
12	Maintenance of Personnel							12
13	Nursing Administration	75		29		1,639	9,804	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	868		332		4,177		16
17	Social Service	94		36		1,018		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	8,604	4,703	3,288	1,686	11,970	3,328	30
31	Intensive Care Unit	786	278	300	287	1,420	395	31
44	Skilled Nursing Facility	5,041	6,628	1,927	5,711	9,592	2,667	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,826	3,822	1,462		6,263	1,741	50
54	Radiology-Diagnostic	2,698	3,037	1,031		5,145		54
60	Laboratory	1,337	590	511		8,964		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	993	350	379		1,948		65
66	Physical Therapy	2,204	2,361	842		4,777		66
69	Electrocardiology		43					69
71	Medical Supplies Charged to Patients	1,047		400		954		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	1,608		614		1,578		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	8,799	465	3,364		12,221		88
90	Clinic	1,023		391		2,256		90
90.01	WOUND CARE							90.01
90.02	CLINIC	639	42	244		978		90.02
90.03	URGENT CARE	1,279	143	489		2,227		90.03
91	Emergency	1,369	6,425	523		6,866	1,673	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,132		432				101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	46,626	33,432	17,491	7,684	83,993	9,804	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	46,626	33,432	17,491	7,684	83,993	9,804	202

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	42,195						16
17	Social Service		6,137					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	2,613	3,277	354,292		354,292		30
31	Intensive Care Unit	187		33,760		33,760		31
44	Skilled Nursing Facility	607	1,181	218,460		218,460		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,226		173,569		173,569		50
54	Radiology-Diagnostic	9,150		137,440		137,440		54
60	Laboratory	6,203		96,538		96,538		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,468		43,820		43,820		65
66	Physical Therapy	1,654		100,073		100,073		66
69	Electrocardiology	606		1,436		1,436		69
71	Medical Supplies Charged to Patients	2,150		44,527		44,527		71
72	Impl. Dev. Charged to Patients	67		3,533		3,533		72
73	Drugs Charged to Patients	3,061		87,392		87,392		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	1,840		370,559		370,559		88
90	Clinic	622	1,679	48,820		48,820		90
90.01	WOUND CARE	67		733		733		90.01
90.02	CLINIC	202		27,261		27,261		90.02
90.03	URGENT CARE	411		55,661		55,661		90.03
91	Emergency	2,061		91,786		91,786		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			46,068		46,068		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	42,195	6,137	1,935,728		1,935,728		118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,195	6,137	1,935,728		1,935,728		202

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	103,467						1
2	Cap Rel Costs-Mvble Equip		103,467					2
4	Employee Benefits Department			12,122,812				4
5	Administrative & General	19,674	19,674	1,311,216	-3,466,939	21,714,764		5
6	Maintenance & Repairs	2,832	2,832	308,302		705,199	80,961	6
7	Operation of Plant	1,851	1,851			620,093	1,851	7
8	Laundry & Linen Service	1,279	1,279			455,654	1,279	8
9	Housekeeping	177	177	335,094		570,866	177	9
10	Dietary	131	131	136,260		279,256	131	10
11	Cafeteria	3,849	3,849	216,667		339,873	3,849	11
12	Maintenance of Personnel							12
13	Nursing Administration	128	128	253,965		328,204	128	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,473	1,473	238,024		476,718	1,473	16
17	Social Service	160	160	81,401		110,228	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	1,160,570		1,769,172	14,599	30
31	Intensive Care Unit	1,333	1,333	172,567		241,820	1,333	31
44	Skilled Nursing Facility	8,553	8,553	704,214		1,075,597	8,553	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,492	6,492	1,073,035		1,272,354	6,492	50
54	Radiology-Diagnostic	4,578	4,578	511,023		1,596,378	4,578	54
60	Laboratory	2,268	2,268	745,651		2,046,208	2,268	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,684	1,684	123,666		284,696	1,684	65
66	Physical Therapy	3,739	3,739	651,516		901,732	3,739	66
69	Electrocardiology			37,568		46,411		69
71	Medical Supplies Charged to Patients	1,776	1,776	51,540		314,194	1,776	71
72	Impl. Dev. Charged to Patients					204,456		72
73	Drugs Charged to Patients	2,728	2,728	223,226		1,610,953	2,728	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	14,931	14,931	2,135,252		3,099,997	14,931	88
90	Clinic	1,735	1,735	302,333		530,789	1,735	90
90.01	WOUND CARE					39,300		90.01
90.02	CLINIC	1,085	1,085	69,033		235,193	1,085	90.02
90.03	URGENT CARE	2,170	2,170	325,665		517,654	2,170	90.03
91	Emergency	2,322	2,322	694,865		1,626,237	2,322	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,920	1,920	260,159		415,532	1,920	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	103,467	103,467	12,122,812	-3,466,939	21,714,764	80,961	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,272,960	662,768	2,853,693		3,466,939	817,790	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.303053	6.405598	0.235399		0.159658	10.101036	203
204	Cost to be allocated (Per Wkst. B, Part II)					368,074	64,936	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.016950	0.802065	205

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 SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINISTRATION DIRECT NRSING HRS	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	79,110						7
8	Laundry & Linen Service	1,279	69,345					8
9	Housekeeping	177	8,829	77,654				9
10	Dietary	131	597	131	85,164			10
11	Cafeteria	3,849		3,849		355,191		11
12	Maintenance of Personnel							12
13	Nursing Administration	128		128		6,933	149,116	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,473		1,473		17,663		16
17	Social Service	160		160		4,305		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	9,755	14,599	18,686	50,619	50,619	30
31	Intensive Care Unit	1,333	577	1,333	3,177	6,006	6,006	31
44	Skilled Nursing Facility	8,553	13,748	8,553	63,301	40,562	40,562	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,492	7,928	6,492		26,484	26,484	50
54	Radiology-Diagnostic	4,578	6,300	4,578		21,756		54
60	Laboratory	2,268	1,224	2,268		37,905		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,684	725	1,684		8,238		65
66	Physical Therapy	3,739	4,897	3,739		20,199		66
69	Electrocardiology		90					69
71	Medical Supplies Charged to Patients	1,776		1,776		4,033		71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	2,728		2,728		6,674		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	14,931	964	14,931		51,687		88
90	Clinic	1,735		1,735		9,541		90
90.01	WOUND CARE							90.01
90.02	CLINIC	1,085	88	1,085		4,136		90.02
90.03	URGENT CARE	2,170	297	2,170		9,416		90.03
91	Emergency	2,322	13,326	2,322		29,034	25,445	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1,920		1,920				101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	79,110	69,345	77,654	85,164	355,191	149,116	118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	737,793	553,250	735,888	332,390	505,386	394,169	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.326166	7.978225	9.476498	3.902940	1.422857	2.643372	203
204	Cost to be allocated (Per Wkst. B, Part II)	46,626	33,432	17,491	7,684	83,993	9,804	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.589382	0.482111	0.225243	0.090226	0.236473	0.065747	205

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	80,284,384						16
17	Social Service		4,920					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	4,968,025	2,627					30
31	Intensive Care Unit	355,008						31
44	Skilled Nursing Facility	1,154,918	947					44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,638,404						50
54	Radiology-Diagnostic	17,459,667						54
60	Laboratory	11,792,288						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,692,775						65
66	Physical Therapy	3,144,904						66
69	Electrocardiology	1,151,781						69
71	Medical Supplies Charged to Patients	4,086,839						71
72	Impl. Dev. Charged to Patients	127,464						72
73	Drugs Charged to Patients	5,819,929						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,498,739						88
90	Clinic	1,182,879	1,346					90
90.01	WOUND CARE	127,086						90.01
90.02	CLINIC	384,522						90.02
90.03	URGENT CARE	780,806						90.03
91	Emergency	3,918,350						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	80,284,384	4,920					118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	620,537	138,576					202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.007729	28.165854					203
204	Cost to be allocated (Per Wkst. B, Part II)	42,195	6,137					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000526	1.247358					205

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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	2,942,576		2,942,576		2,942,576	30
31	Intensive Care Unit	363,126		363,126		363,126	31
44	Skilled Nursing Facility	2,051,816		2,051,816		2,051,816	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,954,947		1,954,947		1,954,947	50
54	Radiology-Diagnostic	2,199,759		2,199,759		2,199,759	54
60	Laboratory	2,593,296		2,593,296		2,593,296	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	432,598		432,598		432,598	65
66	Physical Therapy	1,245,889		1,245,889		1,245,889	66
69	Electrocardiology	63,441		63,441		63,441	69
71	Medical Supplies Charged to Patients	453,015		453,015		453,015	71
72	Impl. Dev. Charged to Patients	238,084		238,084		238,084	72
73	Drugs Charged to Patients	2,001,483		2,001,483		2,001,483	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	4,134,779		4,134,779		4,134,779	88
90	Clinic	726,310		726,310		726,310	90
90.01	WOUND CARE	46,557		46,557		46,557	90.01
90.02	CLINIC	313,663		313,663		313,663	90.02
90.03	URGENT CARE	684,826		684,826		684,826	90.03
91	Emergency	2,198,168		2,198,168		2,198,168	91
92	Observation Beds (Non-Distinct Part)	903,841		903,841		903,841	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	537,370		537,370		537,370	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	26,085,544		26,085,544		26,085,544	200
201	Less Observation Beds	903,841		903,841		903,841	201
202	Total (line 200 minus line 201)	25,181,703		25,181,703		25,181,703	202

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	3,894,789		3,894,789				30
31	Intensive Care Unit	355,008		355,008				31
44	Skilled Nursing Facility	1,154,918		1,154,918				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,487,429	14,150,975	15,638,404	0.125009	0.125009	0.125009	50
54	Radiology-Diagnostic	730,592	16,729,075	17,459,667	0.125991	0.125991	0.125991	54
60	Laboratory	1,022,248	10,770,040	11,792,288	0.219915	0.219915	0.219915	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,389,000	2,303,775	4,692,775	0.092184	0.092184	0.092184	65
66	Physical Therapy	1,141,043	2,003,861	3,144,904	0.396161	0.396161	0.396161	66
69	Electrocardiology	166,263	985,518	1,151,781	0.055081	0.055081	0.055081	69
71	Medical Supplies Charged to Patients	1,088,955	2,777,841	3,866,796	0.117155	0.117155	0.117155	71
72	Impl. Dev. Charged to Patients	15,392	332,115	347,507	0.685120	0.685120	0.685120	72
73	Drugs Charged to Patients	1,428,730	4,391,199	5,819,929	0.343902	0.343902	0.343902	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		3,498,739	3,498,739				88
90	Clinic		1,182,879	1,182,879	0.614019	0.614019	0.614019	90
90.01	WOUND CARE	1,147	125,939	127,086	0.366342	0.366342	0.366342	90.01
90.02	CLINIC		384,522	384,522	0.815722	0.815722	0.815722	90.02
90.03	URGENT CARE		780,806	780,806	0.877076	0.877076	0.877076	90.03
91	Emergency	67,951	3,850,399	3,918,350	0.560993	0.560993	0.560993	91
92	Observation Beds (Non-Distinct Part)	139,046	934,190	1,073,236	0.842164	0.842164	0.842164	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		525,341	525,341				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	15,082,511	65,727,214	80,809,725				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	15,082,511	65,727,214	80,809,725				202

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1311** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.125009		4,063,083			507,922		50
54	Radiology-Diagnostic	0.125991		7,555,893			951,975		54
60	Laboratory	0.219915		4,707,485			1,035,247		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.092184		766,405			70,650		65
66	Physical Therapy	0.396161		744,980			295,132		66
69	Electrocardiology	0.055081		438,578			24,157		69
71	Medical Supplies Charged to Pat	0.117155		1,400,527			164,079		71
72	Impl. Dev. Charged to Patients	0.685120		123,602			84,682		72
73	Drugs Charged to Patients	0.343902		2,445,478			841,005		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	0.614019		1,138,615			699,131		90
90.01	WOUND CARE	0.366342		56,091			20,548		90.01
90.02	CLINIC	0.815722		171,727			140,081		90.02
90.03	URGENT CARE	0.877076							90.03
91	Emergency	0.560993		1,241,348			696,388		91
92	Observation Beds (Non-Distinct	0.842164		479,048			403,437		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			25,332,860			5,934,434		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			25,332,860			5,934,434		202

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-5552** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	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	2	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
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-5552** | **WORKSHEET D PART IV**

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

(A)	Cost Center Description	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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,638,404							50
54	Radiology-Diagnostic	17,459,667			35,081				54
60	Laboratory	11,792,288			54,768				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,692,775			153,868				65
66	Physical Therapy	3,144,904			856,381				66
69	Electrocardiology	1,151,781			1,797				69
71	Medical Supplies Charged to Pat	3,866,796			221,943				71
72	Impl. Dev. Charged to Patients	347,507							72
73	Drugs Charged to Patients	5,819,929			300,218				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	3,498,739							88
90	Clinic	1,182,879							90
90.01	WOUND CARE	127,086							90.01
90.02	CLINIC	384,522							90.02
90.03	URGENT CARE	780,806							90.03
91	Emergency	3,918,350							91
92	Observation Beds (Non-Distinct	1,073,236							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	74,879,669			1,624,056				200

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5552** **WORKSHEET D PART V**

Check Applicable Boxes:

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.125009							50
54	Radiology-Diagnostic	0.125991							54
60	Laboratory	0.219915							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.092184							65
66	Physical Therapy	0.396161							66
69	Electrocardiology	0.055081							69
71	Medical Supplies Charged to Pat	0.117155							71
72	Impl. Dev. Charged to Patients	0.685120							72
73	Drugs Charged to Patients	0.343902							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	0.614019							90
90.01	WOUND CARE	0.366342							90.01
90.02	CLINIC	0.815722							90.02
90.03	URGENT CARE	0.877076							90.03
91	Emergency	0.560993							91
92	Observation Beds (Non-Distinct	0.842164							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	354,292		354,292	2,458	144.14	167	24,071	30
31	Intensive Care Unit	33,760		33,760	253	133.44	45	6,005	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	218,460		218,460	7,545	28.95			44
45	Nursing Facility								45
200	Total (lines 30-199)	606,512		606,512	10,256		212	30,076	200

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1311** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	173,569	15,638,404	0.011099	266,542	2,958	50
54	Radiology-Diagnostic	137,440	17,459,667	0.007872	84,423	665	54
60	Laboratory	96,538	11,792,288	0.008187	102,446	839	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	43,820	4,692,775	0.009338	103,354	965	65
66	Physical Therapy	100,073	3,144,904	0.031821	12,317	392	66
69	Electrocardiology	1,436	1,151,781	0.001247	16,950	21	69
71	Medical Supplies Charged to Pat	44,527	3,866,796	0.011515	99,422	1,145	71
72	Impl. Dev. Charged to Patients	3,533	347,507	0.010167			72
73	Drugs Charged to Patients	87,392	5,819,929	0.015016	139,643	2,097	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	370,559	3,498,739	0.105912			88
90	Clinic	48,820	1,182,879	0.041272			90
90.01	WOUND CARE	733	127,086	0.005768			90.01
90.02	CLINIC	27,261	384,522	0.070896			90.02
90.03	URGENT CARE	55,661	780,806	0.071287			90.03
91	Emergency	91,786	3,918,350	0.023425	8,756	205	91
92	Observation Beds (Non-Distinct	108,824	1,073,236	0.101398			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,391,972	74,879,669		833,853	9,287	200

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE 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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] 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)	2,458		167		30
31	Intensive Care Unit	253		45		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	7,545				44
45	Nursing Facility					45
200	Total (lines 30-199)	10,256		212		200

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1311** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	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	2	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
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1311** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,638,404			266,542				50
54	Radiology-Diagnostic	17,459,667			84,423				54
60	Laboratory	11,792,288			102,446				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,692,775			103,354				65
66	Physical Therapy	3,144,904			12,317				66
69	Electrocardiology	1,151,781			16,950				69
71	Medical Supplies Charged to Pat	3,866,796			99,422				71
72	Impl. Dev. Charged to Patients	347,507							72
73	Drugs Charged to Patients	5,819,929			139,643				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	3,498,739							88
90	Clinic	1,182,879							90
90.01	WOUND CARE	127,086							90.01
90.02	CLINIC	384,522							90.02
90.03	URGENT CARE	780,806							90.03
91	Emergency	3,918,350			8,756				91
92	Observation Beds (Non-Distinct	1,073,236							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	74,879,669			833,853				200

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1311** **WORKSHEET D PART V**

Check Applicable Boxes:

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.125009		3,708,935			463,650		50
54	Radiology-Diagnostic	0.125991		3,669,207			462,287		54
60	Laboratory	0.219915		1,978,806			435,169		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.092184		390,312			35,981		65
66	Physical Therapy	0.396161		242,155			95,932		66
69	Electrocardiology	0.055081		136,509			7,519		69
71	Medical Supplies Charged to Pat	0.117155		1,067,956			125,116		71
72	Impl. Dev. Charged to Patients	0.685120							72
73	Drugs Charged to Patients	0.343902		804,605			276,705		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	0.614019							90
90.01	WOUND CARE	0.366342		54,639			20,017		90.01
90.02	CLINIC	0.815722		116,558			95,079		90.02
90.03	URGENT CARE	0.877076		251,442			220,534		90.03
91	Emergency	0.560993		1,324,452			743,008		91
92	Observation Beds (Non-Distinct	0.842164							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			13,745,576			2,980,997		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			13,745,576			2,980,997		202

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1311** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,458	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,458	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)	1,703	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)	1,125	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)	2,942,576	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)	2,942,576	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)	2,942,576	37

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1311** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,197.14	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,346,783	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)					1,346,783	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	363,126	253	1,435.28	126	180,845	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)					827,914	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,355,542	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 etner 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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					755	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,197.14	88
89	Observation bed cost (line 87 x line 88) (see instructions)					903,841	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	354,292	2,942,576	0.120402	903,841	108,824	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5552** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[XX] SNF**		**[ ] TEFRA**
	[ ] 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)	7,545	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,545	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)	7,545	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)	1,780	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)	2,051,816	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)	2,051,816	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)	2,051,816	37

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[XX] SNF**		**[ ] TEFRA**
	[ ] 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)	2,051,816	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	271.94	71
72	Program routine service cost (line 9 x line 71)	484,053	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)	484,053	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)	484,053	83
84	Program inpatient ancillary services (see instructions)	499,260	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	983,313	86

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1311** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,458	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,458	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)	1,703	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)	167	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)	2,942,576	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)	2,942,576	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)	2,942,576	37

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1311** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,197.14	38
39	Program general inpatient routine service cost (line 9 x line 38)					199,922	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)					199,922	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	363,126	253	1,435.28	45	64,588	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)					146,412	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					410,922	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	30,076	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,287	51
52	Total Program excludable cost (sum of lines 50 and 51)	39,363	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 etner 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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					755	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 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						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1311** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] 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		1,260,000		30
31	Intensive Care Unit		232,974		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.125009	631,767	78,977	50
54	Radiology-Diagnostic	0.125991	545,242	68,696	54
60	Laboratory	0.219915	743,777	163,568	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.092184	801,718	73,906	65
66	Physical Therapy	0.396161	113,527	44,975	66
69	Electrocardiology	0.055081	77,781	4,284	69
71	Medical Supplies Charged to Patients	0.117155	767,590	89,927	71
72	Impl. Dev. Charged to Patients	0.685120	8,448	5,788	72
73	Drugs Charged to Patients	0.343902	752,187	258,679	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	0.614019			90
90.01	WOUND CARE	0.366342	1,147	420	90.01
90.02	CLINIC	0.815722			90.02
90.03	URGENT CARE	0.877076			90.03
91	Emergency	0.560993	35,632	19,989	91
92	Observation Beds (Non-Distinct Part)	0.842164	22,211	18,705	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,501,027	827,914	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,501,027		202

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.125009			50
54	Radiology-Diagnostic	0.125991	35,081	4,420	54
60	Laboratory	0.219915	54,768	12,044	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.092184	153,868	14,184	65
66	Physical Therapy	0.396161	856,381	339,265	66
69	Electrocardiology	0.055081	1,797	99	69
71	Medical Supplies Charged to Patients	0.117155	221,943	26,002	71
72	Impl. Dev. Charged to Patients	0.685120			72
73	Drugs Charged to Patients	0.343902	300,218	103,246	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	0.614019			90
90.01	WOUND CARE	0.366342			90.01
90.02	CLINIC	0.815722			90.02
90.03	URGENT CARE	0.877076			90.03
91	Emergency	0.560993			91
92	Observation Beds (Non-Distinct Part)	0.842164			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,624,056	499,260	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,624,056		202

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1311** **WORKSHEET D-3**

Check Applicable Boxes:

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,032,223		30
31	Intensive Care Unit		53,621		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.125009	266,542	33,320	50
54	Radiology-Diagnostic	0.125991	84,423	10,637	54
60	Laboratory	0.219915	102,446	22,529	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.092184	103,354	9,528	65
66	Physical Therapy	0.396161	12,317	4,880	66
69	Electrocardiology	0.055081	16,950	934	69
71	Medical Supplies Charged to Patients	0.117155	99,422	11,648	71
72	Impl. Dev. Charged to Patients	0.685120			72
73	Drugs Charged to Patients	0.343902	139,643	48,024	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	0.614019			90
90.01	WOUND CARE	0.366342			90.01
90.02	CLINIC	0.815722			90.02
90.03	URGENT CARE	0.877076			90.03
91	Emergency	0.560993	8,756	4,912	91
92	Observation Beds (Non-Distinct Part)	0.842164			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		833,853	146,412	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		833,853		202

(A) Worksheet A line numbers

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1311** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,934,434			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 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)	5,934,434			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 ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	5,993,778			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, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	73,445			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	4,088,424			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)	1,831,909			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)	1,831,909			30
31	Primary payer payments	341			31
32	Subtotal (line 30 minus line 31)	1,831,568			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)	846,669			34
35	Adjusted reimbursable bad debts (see instructions)	550,335			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,228			36
37	Subtotal (see instructions)	2,381,903			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)	2,381,903			40
40.01	Sequestration adjustment (see instructions)	47,638			40.01
41	Interim payments	2,915,726			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-581,461			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 (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5552** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 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 ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 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
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 (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1311** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,769,032		2,915,726	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,769,032		2,915,726	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		201,780			6.01
	based on the cost report (1)		.02				-581,461	6.02
7	Total Medicare program liability (see instructions)				1,970,812		2,334,265	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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	605	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,251	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,956	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	80,809,725	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	249,047	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	1	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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	2,355,542	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,355,542	4
5	Primary payer payments	8,729	5
6	Total cost (see instructions)	2,370,368	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)	2,370,368	19
20	Deductibles (exclude professional component)	408,416	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,961,952	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,961,952	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	75,509	25
26	Adjusted reimbursable bad debts (see instructions)	49,081	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,036	27
28	Subtotal (sum of lines 24 and 26)	2,011,033	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,011,033	30
30.01	Sequestration adjustment (see instructions)	40,221	30.01
31	Interim payments	1,769,032	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	201,780	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART VI

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

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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1311** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	410,922		1
2	Medical and other services		2,980,997	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	410,922	2,980,997	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	410,922	2,980,997	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	833,853	13,745,576	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)	833,853	13,745,576	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	833,853	13,745,576	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)	410,922	2,980,997	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)	410,922	2,980,997	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)	410,922	2,980,997	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)	410,922	2,980,997	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	410,922	2,980,997	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)	410,922	2,980,997	40
41	Interim payments	249,234		41
42	Balance due provider/program (line 40 minus line 41)	161,688	2,980,997	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	571,648				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	8,629,897				4
5	Other receivables	1,067,069				5
6	Allowances for uncollectible notes and accounts receivable	-2,834,013				6
7	Inventory	421,313				7
8	Prepaid expenses	435,860				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,291,774				11
	FIXED ASSETS					
12	Land	449,428				12
13	Land improvements	640,428				13
14	Accumulated depreciation	-573,300				14
15	Buildings	23,872,569				15
16	Accumulated depreciation	-12,414,413				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	1,498,910				19
20	Accumulated depreciation	-1,209,079				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,285,827				23
24	Accumulated depreciation	-9,756,849				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	13,793,521				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	2,226,340				34
35	Total other assets (sum of lines 31-34)	2,226,340				35
36	Total assets (sum of lines 11, 30 and 35)	24,311,635				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	810,654				37
38	Salaries, wages and fees payable	885,170				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	586,176				40
41	Deferred income	335,188				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	380,000				44
45	Total current liabilities (sum of lines 37 thru 44)	2,997,188				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	5,934,101				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	5,934,101				50
51	Total liabilities (sum of lines 45 and 50)	8,931,289				51
	CAPITAL ACCOUNTS					
52	General fund balance	15,380,346				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	15,380,346				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	24,311,635				60

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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		14,749,870			1
2	Net income (loss) (from Worksheet G-3, line 29)		630,476			2
3	Total (sum of line 1 and line 2)		15,380,346			3
4	Additions (credit adjustments) (specify)					4
5	PRIOR YEAR ADJUSTMENTS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		15,380,346			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,380,346			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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,894,789		3,894,789	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,154,918		1,154,918	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	5,049,707		5,049,707	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	355,008		355,008	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	355,008		355,008	16
17	Total inpatient routine care services (sum of lines 10 and 16)	5,404,715		5,404,715	17
18	Ancillary services	9,469,652	54,444,399	63,914,051	18
19	Outpatient services	208,144	7,258,735	7,466,879	19
20	Rural Health Clinic (RHC)		3,498,739	3,498,739	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		525,341	525,341	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PRO FEES	226,682	6,525,403	6,752,085	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	15,309,193	72,252,617	87,561,810	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		28,790,163	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)		28,790,163	43

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	87,561,810	1
2	Less contractual allowances and discounts on patients' accounts	59,169,153	2
3	Net patient revenues (line 1 minus line 2)	28,392,657	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	28,790,163	4
5	Net income from service to patients (line 3 minus line 4)	-397,506	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	98,415	6
7	Income from investments	57,491	7
8	Revenues from telephone and other miscellaneous communication services	50	8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	2,140	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	172,286	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	11,457	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	254,130	22
23	Governmental appropriations		23
24	Other (MISCELLANOUS)	314,956	24
24.01	Other (GRANTS)	21,145	24.01
24.02	Other (DEFERRED REVENUE)		24.02
24.03	Other (SITE FEES)	185,332	24.03
24.04	Other (EHR INCENTIVE)		24.04
24.05	Other (SALE OF SCRAP)	908	24.05
25	Total other income (sum of lines 6-24)	1,118,310	25
26	Total (line 5 plus line 25)	720,804	26
27	Other expenses (OTHER)	90,328	27
28	Total other expenses (sum of line 27 and subscripts)	90,328	28
29	Net income (or loss) for the period (line 26 minus line 28)	630,476	29

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	32,190		30,191	5,692	22,328	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	142,235					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	85,734					23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	260,159		30,191	5,692	22,328	24

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	90,401		90,401		90,401	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	142,235		142,235		142,235	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	85,734		85,734		85,734	23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	318,370		318,370		318,370	24

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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	90,401				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	142,235				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	85,734				23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	318,370				24

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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		90,401	90,401		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		142,235	56,403	198,638	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		85,734	33,998	119,732	23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		318,370		318,370	24

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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					-90,401	227,969	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						142,235	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						85,734	23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-90,401	227,969	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						90,401	25
26	Unit Cost Multiplier						0.396550	26

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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		23,622	12,299	7,577	43,498	6,945	1
2	Skilled Nursing Care	198,638			33,482	232,120	37,060	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	119,732			20,182	139,914	22,338	19
20	Totals (sum of lines 1-19)(2)	318,370	23,622	12,299	61,241	415,532	66,343	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.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	19,394	17,906		18,195			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)	19,394	17,906		18,195			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.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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						105,938	1
2	Skilled Nursing Care						269,180	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						162,252	19
20	Totals (sum of lines 1-19)(2)						537,370	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.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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 PtII)	TOTAL HHA COSTS			
		25	26	27	28			
1	Administrative and General		105,938					1
2	Skilled Nursing Care		269,180	66,097	335,277			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		162,252	39,841	202,093			19
20	Totals (sum of lines 1-19)(2)		537,370	105,938	537,370			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.			0.245550				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.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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	32,190		43,498	1,920	1
2	Skilled Nursing Care			142,235		232,120		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			85,734		139,914		19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	1,920	1,920	260,159		415,532	1,920	20
21	Total cost to be allocated	23,622	12,299	61,241		66,343	19,394	21
22	Unit Cost Multiplier	12.303125		0.235398		0.159658		22
22	Unit Cost Multiplier		6.405729				10.101042	22

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 SERVED	CAFETERIA FTE'S SERVED	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	17,906		18,195				21
22	Unit Cost Multiplier	9.326042		9.476563				22
22	Unit Cost Multiplier							22

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7612** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation

	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	335,277		335,277	2,165	154.86	1
2	Physical Therapy	3				745		2
3	Occupational Therapy	4				270		3
4	Speech Pathology	5				30		4
5	Medical Social Services	6						5
6	Home Health Aide	7				256		6
7	Total (sum of lines 1-6)		335,277		335,277	3,466		7

Limitation Cost Comoputation

			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		1,736		8
9	Physical Therapy	14999		564		9
10	Occupational Therapy	14999		178		10
11	Speech Pathology	14999		19		11
12	Medical Social Services	14999				12
13	Home Health Aide	14999		4		13
14	Total (sum of lines 8-13)			2,501		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	0.396161			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	0.117155			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.343902			col. 2, line 16	5

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7612** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		1,736			268,837		268,837	1
2	Physical Therapy		564						2
3	Occupational Therapy		178						3
4	Speech Pathology		19						4
5	Medical Social Services								5
6	Home Health Aide		4						6
7	Total (sum of lines 1-6)		2,501			268,837		268,837	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

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7612** **WORKSHEET H-4**
PARTS I & II

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

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

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				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 excced 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

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		367,354	11
12	Total PPS Reimbursement - Full Episodes with Outliers		10,913	12
13	Total PPS Reimbursement - LUPA Episodes		6,418	13
14	Total PPS Reimbursement - PEP Episodes		6,243	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			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)		390,928	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		390,928	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		390,928	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)		390,928	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		390,928	31
31.01	Sequestration adjustment (see instructions)		7,870	31.01
32	Interim payments (see instructions)		385,647	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		-2,589	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7612** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						385,647	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						385,647	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02				-2,589	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						383,058	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.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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

Check applicable box: [XX] 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	976,676		976,676	69,660	1,046,336	-98,601	947,735	1
2	Physician Assistant	245,375		245,375		245,375		245,375	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker	138,836		138,836		138,836		138,836	7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	1,360,887		1,360,887	69,660	1,430,547	-98,601	1,331,946	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	Deperciation-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)	1,360,887		1,360,887	69,660	1,430,547	-98,601	1,331,946	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	704,705	278,465	983,170	2,908	986,078		986,078	30
31	Total Facility Overhead (sum of lines 29 and 30)	704,705	278,465	983,170	2,908	986,078		986,078	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	2,065,592	278,465	2,344,057	72,568	2,416,625	-98,601	2,318,024	32

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

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

Check applicable box: **[XX] 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	3.42	15,894	4,200	14,364		1
2	Physician Assistants	1.96	6,375	2,100	4,116		2
3	Nurse Practitioners			2,100			3
4	Subtotal (sum of lines 1 through 3)	5.38	22,269		18,480	22,269	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker	1.81	3,724			3,724	7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	7.19	25,993			25,993	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)	1,331,946	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)	1,331,946	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)	986,078	14
15	Parent provider overhead allocated to facility (see instructions)	1,816,755	15
16	Total overhead (sum of lines 14 and 15)	2,802,833	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	2,802,833	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	2,802,833	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	4,134,779	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 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8500** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	4,134,779	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	168,438	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	3,966,341	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	25,993	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	25,993	6
7	Adjusted cost per visit (line 3 divided by line 6)	152.59	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	152.59	152.59	152.59	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		5,957		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		908,979		11
12	Program covered visits for mental health services (from contractor records)		262		12
13	Program covered cost from mental health services (line 9 x line 12)		39,979		13
14	Limit adjustment for mental health services (see instructions)		39,979		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		948,958		16
16.01	Total program charges (see instructions)(from contractor's records)		743,147		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,089		16.02
16.03	Total program preventive costs (see instructions)		6,498		16.03
16.04	Total program non-preventive costs (see instructions)		676,062		16.04
16.05	Total program cost (see instructions)		682,560		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		97,382		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		129,153		19
20	Net Medicare cost excluding vaccines (see instructions)		682,560		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		133,642		21
22	Total reimbursable Program cost (line 20 plus line 21)		816,202		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)		816,202		26
26.01	Sequestration adjustment (see instructions)		16,324		26.01
27	Interim payments		801,398		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-1,520		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.

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8500** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] Title V** **[ ] Title XIX** **[ ] FQHC** **[XX] Title XVIII**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,331,946	1,331,946	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003017	0.002204	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,018	2,936	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	38,238	9,067	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	42,256	12,003	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,331,946	1,331,946	6
7	Total overhead (from Wkst. M-2, line 16)	2,802,833	2,802,833	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.031725	0.009012	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	88,920	25,259	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	131,176	37,262	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	293	214	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	447.70	174.12	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	225	189	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	100,733	32,909	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)		168,438	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)		133,642	16

FAIRFIELD MEMORIAL HOSPITAL Provider CCN: 14-1311	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/22/2017 Run Time: 08:19 Version: 2017.10 (11/19/2017)

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: [XX] RHC I [ ] FQHC

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				801,398	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		.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 zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				801,398	
	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 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			6.01
	based on the cost report (1)		.02		-1,520	6.02
7	Total Medicare program liability (see instructions)				799,878	

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.