This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1311 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 11/29/2023 10:22 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 11/29/2023 Time: 10:22 am ] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAIRFIELD MEMORIAL HOSPITAL (14-1311) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Kri	stin Boldt	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Kristin Boldt			2
3	Signatory Title	INTERIM CFO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	411, 909	-415, 414	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	1	106		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		65, 728		0	10.00
200.00	TOTAL	0	411, 910	-349, 579	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

FAIRFIELD MEMORIAL HOSPITAL Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1311 Worksheet S-2 Peri od: From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/29/2023 10: 22 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 303 NW 11TH ST PO Box 1.00 1.00 PO Box: City: FAIRFIELD State: IL Zi p Code: 62837 2.00 2.00 County Component Name CCN CBSA Provi der Payment System (P, T, O, or N)

V XVIII XIX Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6. 00 | 7. 00 | 8. 00 Hospital and Hospital-Based Component Identification: 3.00 FAIRFIELD MEMORIAL 99914 3.00 Hospi tal 141311 04/01/2001 N 0 0 HOSPI TAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) Swing Beds - SNF Swing Beds - NF 6.00 6.00 7.00 7.00 8.00 8.00 9.00 Hospital -Based SNF FAIRFIELD MEMORIAL 145552 99914 03/26/1985 Ρ Ν 9.00 HOSPI TAL 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA FAIRFIELD MEMORIAL 147612 99914 05/01/1995 Ρ Ν 12.00 HOSPITAL HHA 13.00 Separately Certified ASC 13.00

14. 00 15. 00 16. 00 17. 00	Separately Certified ASC Hospital -Based Hospice Hospital -Based Health Clinic - RHC Hospital -Based Health Clinic - FQHC Hospital -Based (CMHC) I Renal Dialysis Other	FAIRFIELD RHC	148500	99914		03/13/2009	N	0	N	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
						From: 1.00		To		-
20. 00	Cost Reporting Period (mm/dd/yyyy)					07/01/2022		06/30/2023		20.00
21. 00	Type of Control (see instructions)					2				21.00
					1. 00	2.00		3. 0	10	-
	Inpatient PPS Information				1.00	2.00		3. 0	<i>.</i>	
22. 00	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for	N	N				22.00			
22. 01										22. 01
22. 02	Instructions)  1s this a newly merged hospital that requires a final UCP 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				22. 02
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	rds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	istical a "N" for per 1. Ente he cost ructions)	reas no er as	N	N		N		22.03
22. 04	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4	stical are or "N" for per 1. Ente the cost cructions) 199 beds (	eas no er as						22.04
23. 00	which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admission, 2 if cens of identifying the days method used in the price	sus days, of this or cost	or 3		2 N				23. 00

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1311 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/29/2023 10:22 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00  $\cap$ n 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. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the 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. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 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, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "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) XVIII XIX V 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of

which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1311 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/29/2023 10: 22 am | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	FAI RFI EL	D MEMORIAL HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMM	PLEX IDENTIFICATION DA	ATA Provider CC		eriod: fom 07/01/2022 o 06/30/2023	Worksheet S-2 Part I Date/Time Pre 11/29/2023 10	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Ye period that begins on or after			This base year	is your cost	reporting	
64.00 Enter in column 1, if line 63 i in the base year period, the nu resident FTEs attributable to r settings. Enter in column 2 th resident FTEs that trained in y of (column 1 divided by (column 1	s yes, or your facili mber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
or (corumn r drvrded by (corumn	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)			0.00	0.00	0.000000 Ratio (col.	65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Setting	ysEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs	Unweighted	Ratio (col.	
			Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1 00	2.00	Si te	4.00	F 00	
67.00 Enter in column 1, the program	1. 00	2. 00	3.00	4. 00 0. 00	5. 00 0. 000000	67.00
name associated with each of your primary care programs in which you trained residents. 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)						

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	OSPITAL Ovider CC	N: 14-1311	Period: From 07/01/ To 06/30/	′2022	Workshee Part I Date/Tim 11/29/20	t S-2 e Pre	pared:
					-	1. 00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR For a cost reporting period beginning prior to October 1, 2022, d MAC to apply the new DGME formula in accordance with the FY 2023 (August 10, 2022)?	lid you ok	tain permis	sion from y		N		68. 00
					1.00	2.00	3. 00	
	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does	it conta	nin an IPE s	ubprovi der?	N			70.00
71. 00	Enter "Y" for yes or "N" for no.  If line 70 is yes: Column 1: Did the facility have an approved GM recent cost report filed on or before November 15, 2004? Enter "42 CFR 412. 424(d)(1)(iii)(c)) Column 2: Did this facility train r program in accordance with 42 CFR 412. 424 (d)(1)(iii)(D)? Enter "Column 3: If column 2 is Y, indicate which program year began dur (see instructions)  Inpatient Rehabilitation Facility PPS	IE teachir Y" for ye esidents Y" for ye	ng program i es or "N" fo in a new te es or "N" fo	n the most r no. (see aching r no.			0	71. 00
	Is this facility an Inpatient Rehabilitation Facility (IRF), or d	loes it co	ontain an IR	F	N	T		75. 00
	subprovider? Enter "Y" for yes and "N" for no.  If line 75 is yes: Column 1: Did the facility have an approved GM recent cost reporting period ending on or before November 15, 200 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Coluindicate which program year began during this cost reporting peri	4? Enter program mn 3: If	"Y" for yes in accordan column 2 is	or "N" for ce with 42 Y,			0	76. 00
						1. 00		
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and Is this a LTCH co-located within another hospital for part or all "Y" for yes and "N" for no.			ng period? I	Enter	N N		80. 00 81. 00
86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFR Did this facility establish a new Other subprovider (excluded uni §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				no.	N		85. 00 86. 00
	Is this hospital an extended neoplastic disease care hospital cla 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ssified ι	under sectio	n		N		87. 00
	TOOO(U)(T)(B)(VI): Litter T FOI yes of N FOI no.			Approved Permane Adjustm (Y/N)	ent ent	Number Approv Permane Adjustme 2.00	ed ent ents	
	Column 1: Is this hospital approved for a permanent adjustment to amount per discharge? Enter "Y" for yes or "N" for no. If yes, co 89. (see instructions)			ne				88. 00
	Column 2: Enter the number of approved permanent adjustments.		Wkst. A Lir	e Effecti	ve	Approv	ed	
			No.	Date		Permane Adjustm Amount Dischar	ent Per ge	
22 22	Column 1: If line 88, column 1 is Y, enter the Worksheet A line n	umber	1. 00	2.00		3. 00		89. 00
89.00								
	on which the per discharge permanent adjustment approval was base Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge.	amount						
	Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target	amount						
	Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment t	amount		V 1.00		XI X 2. 00		
	Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.  Title V and XIX Services	amount to the	nter "Y" for	1. 00		2. 00		90.00
90. 00	Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.	amount to the evices? En		1. 00				90.00
90. 00	Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.  Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital serves or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cofull or in part? Enter "Y" for yes or "N" for no in the applicable.	amount o the  vices? Er est report e column.	either in	1.00 N		2. 00 Y		
90. 00 91. 00 92. 00	Column 2: Enter the effective date (i.e., the cost reporting peri beginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.  Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital ser yes or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the confull or in part? Enter "Y" for yes or "N" for no in the applicable column.  Are title XIX NF patients occupying title XVIII SNF beds (dual ce instructions) Enter "Y" for yes or "N" for no in the applicable of	amount o the  vices? Er est report e column. ertificatiolumn.	either in on)? (see	1.00		2.00 Y N N		91. 00 92. 00
90. 00 91. 00 92. 00 93. 00	Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.  Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital serves or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the cofull or in part? Enter "Y" for yes or "N" for no in the applicable are title XIX NF patients occupying title XVIII SNF beds (dual ce instructions) Enter "Y" for yes or "N" for no in the applicable column.  To the cost reporting peribeging in the cost of the cost o	amount o the  vices? Er est report e column. ertification	either in on)? (see	1.00 N N		2.00 Y N N		91. 00 92. 00 93. 00
90. 00 91. 00 92. 00 93. 00 94. 00	Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.  Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital serves or "N" for no in the applicable column.  Is this hospital reimbursed for title V and/or XIX through the confull or in part? Enter "Y" for yes or "N" for no in the applicable are title XIX NF patients occupying title XVIII SNF beds (dual ce instructions) Enter "Y" for yes or "N" for no in the applicable colores this facility operate an ICF/IID facility for purposes of title Does this facility operate an ICF/IID facility for purposes	amount o the  vices? Er est report e column. ertificati column. tle V and	either in on)? (see IXIX? Enter	1.00		2.00 Y N N		91. 00 92. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Date/Time F 11/29/2023	S-2 Prepared:
			1. 00	2. 00	_
98.00 Does title V or XIX follow Medicare (title XVIII) for the	interns and res	sidents post	N 1.00	2.00 N	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"					
column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for				N	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			N	N	98. 02
for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a cr reimbursed 101% of inpatient services cost? Enter "Y" for				N	98. 03
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CA outpatient services cost? Enter "Y" for yes or "N" for no			N d	N	98. 04
in column 2 for title XIX.  98.05 Does title V or XIX follow Medicare (title XVIII) and add  Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in				N	98. 05
column 2 for title XIX.  98.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.	t reimbursed fo mn 1 for title	or Wkst. D, V, and in	N	N	98. 06
Rural Providers			Y		105.00
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	l-inclusive met	thod of payme			106.00
107.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in colu Column 2: If column 1 is Y and line 70 or line 75 is Y, dapproved medical education program in the CAH's excluded	mn 1. (see ins o you train I&F IPF and/or IRF	structions) Rs in an	N		107.00
Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		edul e? See 4	2 N		108.00
	Physi cal 1. 00	Occupati ona		Respi rator	У
			2 00	1 00	
therapy services provided by outside supplier? Enter "Y"		2. 00 N	3. 00 N	4. 00 N	109.00
					109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	e N tal Demonstrati "Y" for yes or	on project (	N §410A If yes,		110.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and W	e N tal Demonstrati "Y" for yes or	on project (	§410A If yes, bugh 215, as	1.00 N	
for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and W	tal Demonstrati "Y" for yes or orksheet E-2, I  the Frontier ( cost reporting column 1 is Y, articipating ir	on project ( - "N" for no. i nes 200 thr  Community period? Ente enter the n column 2.	S410A If yes, bugh 215, as	1. 00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for	tal Demonstrati "Y" for yes or orksheet E-2, I  the Frontier ( cost reporting column 1 is Y, articipating ir	on project ( "N" for no. ines 200 thr  Community period? Ente enter the n column 2. s; and/or "C"	N S410A If yes, bugh 215, as  1.00 N	1. 00 N	110.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.	tal Demonstrati "Y" for yes or orksheet E-2, I  the Frontier ( cost reporting column 1 is Y, articipating ir additional beds  alth Model reporting column 1 is ipating in the	on project ( - "N" for no. i nes 200 thr  Community period? Ente enter the n column 2.	S410A If yes, bugh 215, as	1.00 N	110.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital constration. In column 3, enter the date the hospital constration in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided.	tal Demonstrati "Y" for yes or orksheet E-2, I  the Frontier ( cost reporting column 1 is Y, articipating ir additional beds  alth Model reporting column 1 is ipating in the eased  or "N" for no B, or E only) "93" percent (includes	on project ( "N" for no. ines 200 thr  Community period? Ente enter the n column 2. s; and/or "C"	N S410A If yes, bugh 215, as  1.00 N	1. 00 N	110.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital coparticipation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	tal Demonstrati "Y" for yes or orksheet E-2, I  the Frontier ( cost reporting column 1 is Y, articipating ir additional beds  alth Model reporting column 1 is ipating in the eased  or "N" for no B, or E only) "93" percent (includes ers) based on	on project ( - "N" for no. ines 200 thr  Community period? Ente enter the n column 2. s; and/or "C"  1.00  N	N S410A If yes, bugh 215, as  1.00 N	1. 00 N	111.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is p Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital coparticipation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	tal Demonstrati "Y" for yes or orksheet E-2, I  the Frontier ( cost reporting column 1 is Y, articipating ir additional beds  alth Model reporting column 1 is ipating in the eased  or "N" for no B, or E only) "93" percent (includes ers) based on " for yes or	on project ( "N" for no. ines 200 thr  Community period? Ente enter the column 2. s; and/or "C"  1.00  N	N S410A If yes, bugh 215, as  1.00 N	1. 00 N	111.00

Health Financial Systems	FAIRFIELD MEMORIA	AL HOSPITAL		In Lie	ı of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE		Provi der CCN		Peri od: From 07/01/2022 To 06/30/2023	Worksheet S Part I Date/Time F	S-2 Prepared:
			Premi ums	Losses	11/29/2023 I nsurance	
110 011 :			1.00	2.00	3. 00	0110 01
118.01 List amounts of malpractice premiums an	nd pard rosses:		221, 84	18 0		0118.01
110,000			h a	1.00	2. 00	110.00
118.02 Are malpractice premiums and paid loss. Administrative and General? If yes, so and amounts contained therein.				N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for \$3121 and applicable amendments? (see if "N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 at Enter in column 2, "Y" for yes or "N"	instructions) Enter in ith < 100 beds that qua nd applicable amendment	column 1, "Y" lifies for th	for yes or e Outpatient		N	119.00 120.00
121.00 Did this facility incur and report cospatients? Enter "Y" for yes or "N" for		itable devices	charged to	Υ		121.00
122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in	e related taxes as defi column 1. If column 1					122. 00
the Worksheet A line number where these 123.00 Did the facility and/or its subprovide services, e.g., legal, accounting, tax management/consulting services, from all for yes or "N" for no.	rs (if applicable) purc preparation, bookkeepi	ng, payroll,	and/or			123. 00
If column 1 is "Y", were the majority of professional services expenses, for sellocated in a CBSA outside of the main I"N" for no.	rvices purchased from u hospital CBSA? In colum	inrelated orga	ni zati ons			
Certified Transplant Center Informatio 125.00 Does this facility operate a Medicare-		enter? Enter "	Y" for yes	N		125. 00
and "N" for no. If yes, enter certification 126.00 If this is a Medicare-certified kidney			fication dat	-0		126. 00
in column 1 and termination date, if a			iication uat	.е		120.00
127.00  f this is a Medicare-certified heart    in column 1 and termination date, if a	transplant program, ent oplicable in column 2	er the certif	ication date			127. 00
128.00 If this is a Medicare-certified liver	transplant program, ent	er the certif	ication date	2		128. 00
in column 1 and termination date, if a 129.00 If this is a Medicare-certified lung to			cation date			129. 00
in column 1 and termination date, if a 130.00 If this is a Medicare-certified pancre	pplicable, in column 2.					130. 00
date in column 1 and termination date,	1 1 3 .		tirication			130.00
131.00 If this is a Medicare-certified intesting date in column 1 and termination date,			erti fi cati or	1		131.00
132.00 If this is a Medicare-certified islet in column 1 and termination date, if a	transplant program, ent	er the certif	ication date	<i>y</i>		132. 00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procuin column 1 and termination date, if a		PO), enter th	e OPO number	-		133. 00 134. 00
All Providers  140.00 Are there any related organization or l chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home	or no in column 1. If y e office chain number.	es, and home	office costs			140.00
1.00 If this facility is part of a chain or	2.00 ganization, enter on Li	nes 141 throu	  ah 143 the r	3.00	of the home	9
office and enter the home office contr	actor name and contract					
141. 00 Name: 142. 00 Street:	Contractor's Name: PO Box:		Contracto	or's Number:		141. 00 142. 00
143. 00 Ci ty:	State:		Zip Code:			143.00
					1. 00	
144.00 Are provider based physicians' costs in	ncluded in Worksheet A?	•			Y	144. 00
				1. 00	2. 00	
145.00 If costs for renal services are claimed inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in c Medicare utilization f	olumn 1. If c	olumn 1 is			145. 00
period? Enter "Y" for yes or "N" for u 146.00Has the cost allocation methodology ch Enter "Y" for yes or "N" for no in col yes, enter the approval date (mm/dd/yy	anged from the previous umn 1. (See CMS Pub. 15			N		146. 00

Health Financial Systems	FAIRFIELD MEMO	ORIAL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provi der CC	CN: 14-1311			Worksheet S- Part I	2 repared:
						1.00	_
147.00 Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no			1. 00 N	147.00
148.00Was there a change in the order o						N	148. 00
149.00 Was there a change to the simplif				for no.		N	149.00
	_	Part A	Part B	3 T	itle V	Title XIX	
		1.00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155.00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157. 00 Subprovi der - I RF		N	N		N	N	157.00
158. 00 SUBPROVI DER		N			N.	N.	158. 00 159. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N	ļ	N N	N N	160.00
161.00CMHC		IN IN	N N		N	N N	161.00
TOT. OOKWITE			] IN		IN .		101.00
Mul ti campus						1. 00	
165.00 s this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	ne or more camp	ouses in di	fferent C	BSAs?	N	165. 00
Enter 1 101 yes of N 101 Ho.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						O. C	00 166. 00
						1. 00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Reinvest	ment Act			
167.00 s this provider a meaningful use					r the	Υ	167. 00 168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	HIT assets (see instructi	ons)					168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	? Enter "Y" for yes or "N	l" for no. (see	instructio	ns)		0.0	00169.00
transition factor. (see instruction		14 15 1101 4 0/111	(11116-100	13 11 ),	circor the	0.0	, , , , , , , ,
(222 :	•			Ве	gi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending	date for the r	reporti ng				170.00
					1. 00	2.00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	reported on Wkst. S-3, Pt umn 1. If column 1 is yes	. I, line 2, co	ol. 6? Ente	r	N		0171.00

Health Financia	al Systems FAIRFIELD MEMOF	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND H	OSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Peri od: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Pre	epared:
				Y/N	11/29/2023 10 Date	): 22 am
DADT	LIGORITAL AND LIGORITAL HEATHCARE COMPLEY DELMBHDCC	EMENT OUECTLON	MALDE	1. 00	2. 00	
General mm/dd/yy	<ul> <li>HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI Instruction: Enter Y for all YES responses. Enter I ryy format.</li> <li>BY ALL HOSPITALS</li> </ul>			er all dates in	the	
	Organization and Operation	- hll£	*	N		1 00
	provider changed ownership immediately prior to thing period? If yes, enter the date of the change in a			N		1.00
			Y/N	Date	V/I	
2.00 Has the	provider terminated participation in the Medicare	Program? If	1.00 N	2. 00	3. 00	2.00
yes, entrolled yes, e	ter in column 2 the date of termination and in columny or "I" for involuntary.  Drovider involved in business transactions, including the second of the seco	mn 3, "V" for ng management offices, drug der or its of the board	N			3.00
relation	isiii ps: (see Tiisti ucti olis)		Y/N	Type	Date	
Fi nonci o	J. Data and Danasta		1.00	2. 00	3. 00	
4.00 Column Accounts or "R" 1 column 3	<ul> <li>Il Data and Reports</li> <li>Were the financial statements prepared by a Cerant? Column 2: If yes, enter "A" for Audited, "C" for Reviewed. Submit complete copy or enter date av.</li> <li>(see instructions) If no, see instructions.</li> </ul>	for Compiled, ailable in	N			4.00
	cost report total expenses and total revenues differ in the filed financial statements? If yes, submit re		N			5. 00
THOSE OF	Tello Tirod Tiridioi di Statomonto. Ti yesi, Sasim tiro	concretation.		Y/N	Legal Oper.	
Approved	I Educational Activities			1. 00	2. 00	
6. 00 Col umn	1: Are costs claimed for a nursing program? Column al operator of the program?	2: If yes, is	s the provide	n N		6. 00
7.00 Are cost 8.00 Were nur	an operator of the programs? Its claimed for Allied Health Programs? If "Y" see in rsing programs and/or allied health programs approve porting period? If yes, see instructions.		wed during the	e N N		7. 00 8. 00
9.00 Are cost	ts claimed for Interns and Residents in an approved in the current cost report? If yes, see instruction		cal education	N		9. 00
10.00 Was an a	approved Intern and Resident GME program initiated		the current	N		10.00
11.00 Are GME	corting period? If yes, see instructions.  cost directly assigned to cost centers other than g Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.00
					Y/N 1. 00	
Bad Debt						
13.00 If line	provider seeking reimbursement for bad debts? If year 12 is yes, did the provider's bad debt collection	s, see instruct policy change o	tions. during this co	ost reporting	Y N	12. 00 13. 00
1.	If yes, submit copy. 12 is yes, were patient deductibles and/or coinsurations.	ance amounts wa	aived? If yes,	see	N	14. 00
Bed Comp 15.00 Did tota	olement al beds available change from the prior cost report	ing period? If	yes, see ins	tructions.	N	15. 00
, , , , , , , , ,	, , , , , , , , , , , , , , , , , , ,	Par	t A	Par	t B	
		Y/N 1.00	2.00	Y/N 3. 00	Date 4.00	
	cost report prepared using the PS&R Report only? er column 1 or 3 is yes, enter the paid-through	N		N		16. 00
date of instruct 17.00 Was the totals a	the PS&R Report used in columns 2 and 4 .(see tions) cost report prepared using the PS&R Report for and the provider's records for allocation? If	Y	11/06/2023	Y	11/06/2023	17. 00
in colur 18.00 If line Report o but are	column 1 or 3 is yes, enter the paid-through date mns 2 and 4. (see instructions)  16 or 17 is yes, were adjustments made to PS&R data for additional claims that have been billed not included on the PS&R Report used to file this	N		N		18. 00
19.00 If line Report o	oort? If yes, see instructions. 16 or 17 is yes, were adjustments made to PS&R data for corrections of other PS&R Report tion? If yes, see instructions.	N		N		19.00

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL In L	ieu of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1311 Period: From 07/01/20 To 06/30/20	Worksheet S 22 Part II	S-2 Prepared:
Description Y/N	Y/N	
0 1.00	3.00	20.00
20.00   If line 16 or 17 is yes, were adjustments made to PS&R   Report data for Other? Describe the other adjustments:	N	20.00
Y/N Date Y/N	Date	
1.00 2.00 3.00	4. 00	
21.00 Was the cost report prepared only using the provider's N N records? If yes, see instructions.		21.00
	1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
Capital Related Cost		
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost	N	23. 00
reporting period? If yes, see instructions.  24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period lf yes, see instructions	1? N	24. 00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	25. 00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26. 00
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27. 00
Interest Expense 28.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting	N	28. 00
period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)	N	29. 00
treated as a funded depreciation account? If yes, see instructions  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see	N	30. 00
<ul><li>instructions.</li><li>31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.</li></ul>	N	31.00
Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual	N	32.00
arrangements with suppliers of services? If yes, see instructions.  33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding?	If N	33. 00
no, see instructions. Provi der-Based Physicians		
34.00 Were services furnished at the provider facility under an arrangement with provider-based physicial	ns? Y	34.00
If yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-base		35. 00
physicians during the cost reporting period? If yes, see instructions.		
Y/N	Date	
Llama Office Coots	2. 00	
Home Office Costs  36.00 Were home office costs claimed on the cost report?  N		36.00
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  N  If yes, see instructions.		37. 00
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		38.00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		39. 00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.		40. 00
1.00	2. 00	
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		41.00
42.00 Enter the employer/company name of the cost report BLUE & CO., LLC preparer.		42.00
	LUEANDCO. COM	43. 00

Health Financial Systems FALE		In Lieu	of Form CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provi der CCN:	F	eriod: rom 07/01/2022 o 06/30/2023	Worksheet S-2 Part II Date/Time Pre 11/29/2023 10	pared:
		3.00				
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/po		ANAGER				41.00
held by the cost report preparer in columns 1, 2 respectively.	2, and 3,					
42.00 Enter the employer/company name of the cost repo	ort					42.00
preparer.						
43.00 Enter the telephone number and email address of						43.00
report preparer in columns 1 and 2, respectively	у.					

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1311 Peri od: Worksheet S-3 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/29/2023 10:22 am I/P Days / 0/P Visits / Tri ps Bed Days CAH/REH Hours Component Worksheet A No. of Beds Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 42, 792. 00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 21 7,665 1.00 0 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 21 42, 792. 00 7.00 7.665 0 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 1,460 2, 520. 00 0 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 25 9, 125 45, 312. 00 0 14.00 15.00 CAH visits 15.00 15. 10 REH hours and visits 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00

44.00

101.00

30.00

88.00

89.00

30.00

10, 950

0

30

55

0

0

18.00

19.00

20.00

21.00

23.00

24.00

24.10

25.00

27.00

28.00

29 00

30.00

31.00

32.00 32.01

33.00

33.01

34.00

0 22.00

0 26 00

0 26. 25

0

18.00

19.00

20.00

21.00

22.00

23.00

24.00

24. 10

25.00

26 00

26. 25

27.00

28.00

29 00

30.00

31.00

32.00

32.01

33.00

SUBPROVI DER

HOSPI CE

CMHC - CMHC

NURSING FACILITY

OTHER LONG TERM CARE

HOME HEALTH AGENCY

RHC (CONSOLI DATED)

Ambulance Trips

Observation Bed Days

LTCH non-covered days

SKILLED NURSING FACILITY

HOSPICE (non-distinct part)

Total (sum of lines 14-26)

Employee discount days - IRF

AMBULATORY SURGICAL CENTER (D. P.)

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions)
Total ancillary labor & delivery room

outpatient days (see instructions)

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

Peri od: Worksheet S-3 From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared: 11/29/2023 10: 22 am

						11/29/2023 10	:22 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART I - STATISTICAL DATA			,	T		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 113	11	1, 783			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)		405				
2.00	HMO and other (see instructions)	0	135	•			2.00
3.00	HMO IPF Subprovi der	0	0				3.00
4. 00	HMO I RF Subprovi der	0	0	l .			4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	1			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 113	11	1, 783			7. 00
0.00	beds) (see instructions)	40		405			0.00
8.00	I NTENSI VE CARE UNI T	42	0	105			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	4 455					13.00
14.00	Total (see instructions)	1, 155	11		0. 00	299. 09	
15.00	CAH visits	0	0				15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER	1 100	0	7 570	0.00	20. 70.	18.00
19. 00	SKILLED NURSING FACILITY	1, 108	0	7, 570	0. 00	29. 70	
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	1 000	0	0 774	0.00	, ,,	21.00
22. 00	HOME HEALTH AGENCY	1, 838	0	2, 771	0. 00	6. 44	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC	( 420	422	24.207	0.00	40.40	25.00
26. 00	RHC (CONSOLI DATED)	6, 430	433			49. 49	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	O			
27. 00	Total (sum of lines 14-26)		7	700	0. 00	384. 72	
28. 00	Observation Bed Days		/	793			28.00
29. 00	Ambul ance Tri ps	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		0				31.00
32. 00	Labor & delivery days (see instructions)	0	0				32.00
32. 01	Total ancillary labor & delivery room			O			32. 01
22 00	outpatient days (see instructions)						33.00
33.00	LTCH site poutral days and discharges	0					
33. 01	LTCH site neutral days and discharges	0	0				33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

| Peri od: | Worksheet S-3 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: 
 Heal th Financial
 Systems
 FAIRFIELD
 MEMORIAL
 HOSPITAL

 HOSPITAL
 AND
 HOSPITAL
 HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 Provi der CCN: 14-1311

				To	06/30/2023	Date/Time Prep 11/29/2023 10:	
		Full Time		Di sch	arges	1172772023 10.	. 22 (1111
		Equi val ents			9		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	387	4	573	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			0	43		2.00
3. 00	HMO I PF Subprovi der				0		3. 00
4.00	HMO I RF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospi tal Adul ts & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0 00
8. 00	I NTENSI VE CARE UNI T						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12.00
14. 00	Total (see instructions)	0.00	0	387	4	573	13. 00 14. 00
15. 00	CAH visits	0.00	U	307	4	3/3	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF			•			16. 00
17. 00	SUBPROVI DER - I RF			•			17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	0.00					19. 00
20. 00	NURSING FACILITY	0.00		•			20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLI DATED)	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	,			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care					l	34. 00

Heal th	Financial Systems	FAIRFIELD MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA		Provi der C		eriod: rom 07/01/2022	Worksheet S-4	
			Component	CCN: 14-7612 T		Date/Time Pre 11/29/2023 10	
					Home Health	PPS	. ZZ dili
					Agency I		
						00	
0.00	County	T: +1 o 1/	T: +1 o V/////		WAYNE Other	Total	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	4. 00	Total 5.00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA				0		1 00
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	0 119. 00				1. 00 2. 00
				Number of Empl	oyees (Full Ti	me Equivalent)	
		F-+ +b		C+-66	C++	T-+-1	
		Enter the number		Staff	Contract	Total	
	NOVE WENT THE ASENCY AND MEDICAL STREET	0	1	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40. 00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0. 00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			2. 05 3. 86			5. 00 6. 00
7.00	Nursi ng Supervi sor			0. 00	0. 00	0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0. 51 0. 00			8. 00 9. 00
10.00	Occupational Therapy Service			0. 00			10.00
11.00	Occupational Therapy Supervisor			0.00			11.00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 02 0. 00			12. 00 13. 00
14.00	Medical Social Service			0.00			
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. 00 0. 00			15. 00 16. 00
17. 00	Home Health Aide Supervisor			0.00	0. 00	0.00	17. 00
18. 00	Other (specify)			0.00	0.00	0.00 CBSA Data	18. 00
						1.00	
10 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where	you provided so	prvi cos duri na	the cost repor	sting poriod	1	19. 00
20. 00	List those CBSA code(s) in column 1 serviced					1	20.00
	first code).	Full Ep	i sodes				
		Wi thout		LUPA Epi sodes	PEP Only	Total (cols.	
		0utliers 1.00	2.00	3, 00	Epi sodes 4.00	1-4) 5. 00	
	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	875 117, 789	114 15, 243				21. 00 22. 00
23. 00	Physical Therapy Visits	370	139	17	6	532	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	49, 859 157	18, 730 99			1	24. 00 25. 00
26. 00	Occupational Therapy Visit Charges	21, 167	13, 358	•			
27. 00	Speech Pathology Visits	7 980	16		_		27.00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	980	2, 240 0				28. 00 29. 00
30.00	Medical Social Service Visit Charges	0	0				30.00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	75	0				31. 00 32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	1, 410	368				
34. 00	29, and 31) Other Charges	0	0	0	0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	189, 870	49, 571				35.00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	186		23	2	211	36. 00
	outlier)	130					
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	63, 039	23 1, 666		1 16		37. 00 38. 00
	,		., 200	' . 50	,		

HUSDIT	Financial Systems AL-BASED RHC/FQHC STATISTICAL DATA	FAIRFIELD MEMO		CN: 14-1311	Period:	Worksheet S		332-1
HUSPI I	AL-BASED RHC/FUHC STATISTICAL DATA		Provider C	CN: 14-1311	From 07/01/2022		-8	
			Component	CCN: 14-8500	To 06/30/2023			
					RHC I	11/29/2023 Cost		22 ar
					KHC I	COST		
					1.	00		
4 00	Clinic Address and Identification				200 NW 44TH CT	DEET		4.0
1. 00	Street		C	ty	303 NW 11TH ST State	ZIP Code	4	1.0
				00	2.00	3. 00		
2. 00	City, State, ZIP Code, County		FAI RFI ELD			62837		2. 0
						1 00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "P" for rur	al or "II" for	urhan		1.00	0	3.0
3.00	THOSE THE BASED TUNES ONET. DESIGNATION - EITE	ei k foi fui	al of 0 Tol		nt Award	Date	U	3.0
					1. 00	2. 00		
	Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS							4. 00 5. 00
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34							6.0
7. 00	Appalachian Regional Commission	o(d), This Act)						7. 0
8.00	Look-Alikes							8. 0
9. 00	OTHER (SPECIFY)							9. 0
					1. 00	2. 00	+	
10. 00	Does this facility operate as other than a h	ospi tal -based	RHC or FOHC? F	nter "Y" for		2.00	0	10. 0
10.00	yes or "N" for no in column 1. If yes, indic							10.0
	2. (Enter in subscripts of line 11 the type o							
	hours.)						- 1	
		C		1	la a da	Torradare		
			nday to		londay	Tuesday		
		from 1.00	to 2.00	from 3.00	londay to 4.00	from		
	Facility hours of operations (1)	from	to	from 3.00	to			
11. 00	Facility hours of operations (1)	from	to	from	to	from		11.0
11. 00		from	to	from 3.00	to 4.00	from 5.00		11.00
	CLI NI C	from 1.00	to 2.00	from 3.00	to 4.00	from 5.00		11.00
12. 00		from 1.00  on to the prod	to 2.00	from 3.00 08:30	05: 00 1. 00 N	from 5.00		12.0
12. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the	05: 00 1. 00 N	from 5.00		12.0
12. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the	05: 00 1. 00 N	from 5.00		12.0
12. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the ders and	to 4.00	from 5.00		12.0
12. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov	05:00 1.00 N Y	from 5.00		12.0
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RH	to 4.00 05:00 1.00 N Y	From 5. 00   08: 30   2. 00   CCN   2. 00   148500	5	12. 0 13. 0
12. 00 13. 00 14. 00 14. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RH HORIZON HEAL	to 4.00 05:00 1.00 N Y	From 5. 00  08: 30  2. 00  CCN 2. 00  148500 148591	5	12. 0 13. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RH HORIZON HEAL HORIZON HEAL	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE	From 5. 00  08: 30  2. 00  CCN 2. 00  148500 148591 148602	5	12. 0 13. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RH HORIZON HEAL HORIZON HEAL HORIZON HEAL	to 4.00 05:00 1.00 N Y	From 5. 00  08: 30  2. 00  CCN 2. 00  148500 148591	5	12. 0 13. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RH HORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE	From 5.00  08:30  2.00  CCN 2.00  148500 148591 148602 148614	5	11. 00 12. 00 13. 00 14. 00 14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI	From 5.00  08:30  2.00  CCN 2.00  148500 148591 148602 148614  148656	5	12. 0 13. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.	from 1.00  on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	From 3.00  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C XVIII	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI	CCN 2.00 148500 148614 148656 Total Visits	5	12. 0 13. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03 14. 04	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.  RHC/FQHC name, CCN	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	from 3.00  08:30  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI	From 5.00  08:30  2.00  CCN 2.00  148500 148591 148602 148614  148656	5	12. 0 13. 0 14. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	From 3.00  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C XVIII	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI  MORIAL HOSPITAL  XIX	CCN 2.00 148500 148614 148656 Total Visits	5	12. 0 13. 0 14. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03 14. 04	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	From 3.00  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C XVIII	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI  MORIAL HOSPITAL  XIX	From 5. 00  08: 30  2. 00  CCN 2. 00  148500 148591 148602 148614  148656  Total Visits	5	12. 0 13. 0 14. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03 14. 04	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.  RHC/FQHC name, CCN  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	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	From 3.00  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C XVIII	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI  MORIAL HOSPITAL  XIX	From 5. 00  08: 30  2. 00  CCN 2. 00  148500 148591 148602 148614  148656  Total Visits	5	12. 0 13. 0 14. 0 14. 0 14. 0
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03 14. 04	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN  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	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	From 3.00  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C XVIII	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI  MORIAL HOSPITAL  XIX	From 5. 00  08: 30  2. 00  CCN 2. 00  148500 148591 148602 148614  148656  Total Visits	5	12. 00 13. 00 14. 00 14. 00 14. 00
12. 00 13. 00 14. 00 14. 01 14. 02 14. 03 14. 04	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below.  RHC/FQHC name, CCN  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	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colus s of all provi	From 3.00  ard? r 9, section mn 2 the ders and  Prov  FAIRFIELD RHORIZON HEAL HORIZON HEAL HORIZON HEAL CLINIC FAIRFIELD ME URGENT C XVIII	to 4.00  05:00  1.00  N Y  ider name 1.00  IC THCARE THCARE GRAYVILLE THCARE CARMI  MORIAL HOSPITAL  XIX	From 5. 00  08: 30  2. 00  CCN 2. 00  148500 148591 148602 148614  148656  Total Visits	5	12. 0 13. 0 14. 0 14. 0 14. 0 14. 0

Health Financial Systems	FAIRFIELD MEMO	RIAL HOSPITAL		In Lie	2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1311	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8500	From 07/01/2022 To 06/30/2023		epared: ): 22 am
				RHC I	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County						2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	05: 00	08: 30	05: 00	08: 30	05: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 30	05: 00				11. 00

Heal th	Financial Systems FAIRFIELD MEMORIAL	. HOSPI TAL		In Lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO	CN: 14-1311	Peri od:	Worksheet S-1			
				From 07/01/2022	Doto/Time Dro	narad.		
				To 06/30/2023	Date/Time Pre 11/29/2023 10	pareu: :22 am		
					1. 00			
	Uncompensated and indigent care cost computation							
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 col un	n 8)	0. 306184	1.00		
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				E 147 490	2.00		
2. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid?				5, 467, 680 N	3.00		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	ai d?	N N	4.00				
5. 00	If line 4 is no, then enter DSH and/or supplemental payments f				0	5. 00		
6.00	Medi cai d charges				29, 700, 182	6.00		
7.00	Medicaid cost (line 1 times line 6)				9, 093, 721			
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of li	nes 2 and 5; if	3, 626, 041	8. 00		
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions f</pre>	For each lin	20)					
9. 00	Net revenue from stand-alone CHIP	or each fir	16)		0	9.00		
10.00	Stand-alone CHIP charges				Ö			
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	0	12.00		
	enter zero)		~	`				
13. 00	Other state or local government indigent care program (see ins				0	13. 00		
14. 00								
00	00   Charges for patients covered under state or local indigent care program (Not included in lines 6 or   0   10)							
15.00	State or local indigent care program cost (line 1 times line 1		0					
16. 00	Difference between net revenue and costs for state or local in	ndigent care	e program (li	ne 15 minus line	0	16. 00		
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, Ch	IID and stat	te/Local indi	gent care progra	ms (saa			
	instructions for each line)	iii ana stat	corrocar rriar	gent care progre	11113 (300			
17.00		undi ng char	rity care		0	17. 00		
18.00	Government grants, appropriations or transfers for support of				0			
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	al indigent	care program	s (sum of lines	3, 626, 041	19. 00		
	0, 12 dilu 10)		Uni nsured	Insured	Total (col. 1			
			patients	patients	+ col . 2)			
			1. 00	2. 00	3. 00			
	Uncompensated Care (see instructions for each line)		1 100 7		4 400 70/			
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	acility	1, 103, 7	26 0	1, 103, 726	20.00		
21. 00	Cost of patients approved for charity care and uninsured disco	ounts (see	337, 9	43 0	337, 943	21.00		
	instructions)							
22. 00	Payments received from patients for amounts previously writter	n off as		0	0	22. 00		
00.00	charity care		207.0	40	207.040	00.00		
23. 00	Cost of charity care (line 21 minus line 22)		337, 9	43 0	337, 943	23.00		
					1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patie	ent days bey	yond a Length	of stay limit	N	24. 00		
	imposed on patients covered by Medicaid or other indigent care			,				
25. 00	If line 24 is yes, enter the charges for patient days beyond t	the indigent	t care progra	m's length of	0	25. 00		
26. 00	stay limit Total bad debt expense for the entire hospital complex (see in	nstructi one)	١		4, 616, 153	26. 00		
27. 00	Medicare reimbursable bad debts for the entire hospital complex				699, 887	1		
27. 00	Medicare allowable bad debts for the entire hospital complex (				1, 076, 748	1		
28. 00	Non-Medicare bad debt expense (see instructions)		,		3, 539, 405	1		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	opense (see	instructions	5)	1, 460, 570	1		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 798, 513	1		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ıne 30)			5, 424, 554	31.00		

Health Financial Systems	FAIRFIELD MEMORI	_		In Lie	u of Form CMS-2	<u> 2552-10</u>
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 14-1311   F	Peri od:	Worksheet A	
				rom 07/01/2022	D. I. (T' D	
				To 06/30/2023		parea:
Coot Conton Decemintion	Colorico	O+box	Total (ool 1	Recl assi fi cat	11/29/2023 10	: 22 alli
Cost Center Description	Sal ari es	0ther			Reclassified	
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT		2, 737, 567			3, 227, 084	1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP	ı	659, 745	659, 745	0	659, 745	2.00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 344, 431	5, 344, 431	0	5, 344, 431	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	2, 375, 069	3, 996, 554	6, 371, 623	-81, 482	6, 290, 141	5.00
6. 00 00600 MAINTENANCE & REPAIRS	497, 567	334, 015			831, 582	6.00
7.00 00700 OPERATION OF PLANT	0	869, 546			869, 546	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	o	560, 624			560, 624	8.00
9. 00   00900   HOUSEKEEPI NG	703, 088	139, 061	842, 149		842, 149	9.00
1 1					· ·	
10. 00   01000   DI ETARY	547, 224	429, 706			361, 095	10.00
11. 00   01100   CAFETERI A	0	0	(		615, 835	11.00
13. 00 O1300 NURSING ADMINISTRATION	423, 013	57, 705			480, 718	13.00
14.00  01400   CENTRAL SERVICES & SUPPLY	91, 493	58, 860	150, 353	-52, 915	97, 438	14.00
15. 00  01500 PHARMACY	305, 184	1, 782, 343	2, 087, 527	-3, 080	2, 084, 447	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	386, 322	125, 659	511, 981	ıl ol	511, 981	16.00
17. 00   01700   SOCI AL   SERVI CE	137, 576	4, 439	142, 015	sl ol	142, 015	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	1017010	.,		-1	,	
30. 00   03000   ADULTS & PEDI ATRI CS	1, 602, 163	878, 892	2, 481, 055	-59, 721	2, 421, 334	30.00
31. 00   03100   NTENSI VE CARE UNI T	19, 866	5, 119			20, 704	31.00
		·				
44. 00 O4400 SKILLED NURSING FACILITY	1, 129, 751	109, 506	1, 239, 257	7 -7, 982	1, 231, 275	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	1, 228, 245	3, 296, 214				50.00
53. 00   05300   ANESTHESI OLOGY	951, 408	72, 346			0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	878, 312	1, 197, 163	2, 075, 475	-104, 987	1, 970, 488	54.00
60. 00   06000   LABORATORY	1, 096, 131	2, 298, 468	3, 394, 599	-1, 597, 013	1, 797, 586	60.00
65. 00 06500 RESPIRATORY THERAPY	225, 709	127, 951	353, 660	-97, 918	255, 742	65.00
66. 00 06600 PHYSI CAL THERAPY	800, 050	92, 446	892, 496	-67, 729	824, 767	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	214, 826	. 0	214, 826		214, 917	67.00
68. 00 06800 SPEECH PATHOLOGY	116, 004	0	116, 004		120, 960	68.00
69. 00   06900   ELECTROCARDI OLOGY	0	0	110,00-		35, 146	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	1			71.00
		0		,	2, 808, 278	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		1, 927, 228	1, 927, 228	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0		0	0	73.00
76. 00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	198, 317	119, 817	318, 134	1	318, 034	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	4, 238, 158	669, 199	4, 907, 357	81, 482	4, 988, 839	88.00
90. 00  09000 CLI NI C	1, 932, 710	193, 501	2, 126, 211	-65, 542	2, 060, 669	90.00
90. 01 09001 WOUND CARE	ol	0	1	ol ol	0	90.01
90. 02 09002 PAIN CLINIC	126, 802	122, 138	248, 940	-4	248, 936	90.02
90. 03   09003   UROLOGY   CLI NI C	1, 012, 552	61, 456			1, 041, 441	90.03
91. 00 09100 EMERGENCY	1, 088, 386	2, 512, 436			3, 514, 702	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,000,300	2, 312, 430	3,000,022	-00, 120	3, 314, 702	92.00
		0	,		0	
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	(	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS			_	.1 _1		
95. 00 09500 AMBULANCE SERVICES	0	0	(		0	95.00
101.00 10100 HOME HEALTH AGENCY	361, 855	101, 425	463, 280	62, 682	525, 962	
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	(	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE		489, 517	489, 517	-489, 517	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	22, 687, 781	29, 447, 849			52, 135, 630	
NONREI MBURSABLE COST CENTERS	, ,,,,,,,,,	, , 3 , ,	, , , , , , , , , , , ,	·	. ,,	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	66	66	0	44	192. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	22, 687, 781	29, 447, 915				
200.00   TOTAL (SOW OF LINES FIRE CITIONS 199)	22,001,101	27,441,710	1 32, 133, 090	기	JZ, 135, 090	200.00

 
 Heal th Financial
 Systems
 FAIRFIELD MEMORIAL
 HOSPITAL

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider (
 Provi der CCN: 14-1311

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/29/2023 10: 22 am

				11/29/20	<u> </u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		, ,	Allocation		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	-466, 320	2, 760, 764		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	100, 320	659, 745		2.00
		07 001			
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-87, 981	5, 256, 450		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-1, 735, 421	4, 554, 720		5. 00
6.00	00600 MAINTENANCE & REPAIRS	-12, 209			6.00
7.00	00700 OPERATION OF PLANT	0	869, 546		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	560, 624		8.00
9.00	00900 HOUSEKEEPI NG	0	842, 149		9. 00
10.00	01000 DI ETARY	0	361, 095		10.00
11. 00	01100 CAFETERI A	-242, 701	373, 134		11.00
13. 00	01300 NURSING ADMINISTRATION	212,701	480, 718		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-3, 939			14.00
		-3, 939			
15. 00	01500 PHARMACY	0	2, 084, 447		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-12, 240			16. 00
17.00		0	142, 015		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00		-289, 927	2, 131, 407		30.00
31.00		0			31.00
44. 00		0			44.00
11.00	ANCILLARY SERVICE COST CENTERS		1,201,270		
50. 00	05000 OPERATING ROOM	-1, 051, 196	1, 838, 595		50.00
		-1,031,190			•
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1,,,		54.00
60.00	06000 LABORATORY	0	1, 797, 586		60.00
65.00	06500 RESPI RATORY THERAPY	0	255, 742		65.00
66.00	06600 PHYSI CAL THERAPY	0	824, 767		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	214, 917		67.00
68. 00	06800 SPEECH PATHOLOGY	0	120, 960		68.00
69. 00	06900 ELECTROCARDI OLOGY	-35, 146			69.00
71. 00		00, 110	2, 808, 278		71.00
72. 00		0			72.00
		0	., ,		
73. 00		0	0		73.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	318, 034		76.00
77. 00		0	0		77. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	-509, 148	4, 479, 691		88. 00
90.00	09000 CLI NI C	-1, 328, 504	732, 165		90.00
90. 01	09001 WOUND CARE	0			90. 01
90. 02	09002 PAIN CLINIC	0	248, 936		90. 02
90. 03	09003 UROLOGY CLINIC	-820, 897	220, 544		90.03
91.00		-1, 883, 232	1, 631, 470		91.00
92.00					92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		93. 99
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	0	0		95.00
101.00	10100 HOME HEALTH AGENCY	0	525, 962		101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	o		102.00
	SPECIAL PURPOSE COST CENTERS		-1		
113 00	11300   NTEREST EXPENSE	0	0		113. 00
118.00		-8, 478, 861	43, 656, 769		118.00
110.00	NONREIMBURSABLE COST CENTERS	-0,470,001	45,000,709		
102.00					102.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0 470 0/1			192.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-8, 478, 861	43, 656, 835		200. 00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS	Provi der CCN: 14-1311	Period: Worksheet A-6 From 07/01/2022		

					To 06/30/2023 Date/Time Pr	repared:
		Increases			117 277 2023	10. 22 aiii
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4. 00	5. 00		
	A - CAFETERIA	0.00	00	0.00		_
1.00	CAFETERI A	11. 00	344, 958	270, 877		1.00
00	TOTALS	+	344, 958	270, 877		
	B - EKG		011,700	2.0,0		
1.00	ELECTROCARDI OLOGY	69. 00	35, 146	0		1.00
00	TOTALS		35, 146	<del>-</del> <del>0</del>		
	C - INTEREST		337 1.0	<u> </u>		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	489, 517		1.00
00	TOTALS			489, 517		1
	D - IMPLANTS		<u> </u>	107,017		_
1.00	IMPL. DEV. CHARGED TO	72. 00	0	1, 927, 228		1.00
00	PATI ENTS	, 2. 00	ŭ.	1,727,220		
	TOTALS	+		1, 927, 228		i
	E - PT OT ST		<u>~</u>	177277220		
1.00	OCCUPATIONAL THERAPY	67. 00	0	15, 661		1.00
2. 00	SPEECH PATHOLOGY	68. 00		6, 288		2. 00
2.00	TOTALS	<del></del>	0	21, 949		2.00
	F - HHA THERAPIST		<u> </u>	2.17 7.17		
1.00	HOME HEALTH AGENCY	101.00	62, 682	0		1.00
2. 00	Thomas Tracketti Albanot	0.00	02,002	Ö		2.00
3. 00		0. 00	0	0		3.00
0.00	TOTALS — — — —		6 <u>2, 682</u>	<del>-</del> <del>-</del> <del>-</del> <del>-</del>		0.00
	G - RHC RECRUITING		02, 002	<u> </u>		
1.00	RURAL HEALTH CLINIC	88. 00	0	81, 482		1.00
	TOTALS	==+	0	81, 482		1
	H - MEDICAL SUPPLIES			0.7.10=		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	4, 735, 506		1.00
00	PATI ENTS	, 55		1,700,000		
2.00		0.00	0	0		2. 00
3. 00		0.00	0	0		3. 00
4. 00		0.00	o	Ö		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	o	Ö		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	o	0		8.00
9. 00		0.00	o	Ö		9. 00
10.00		0.00	O	0		10.00
11. 00		0.00	ol	Ö		11.00
12. 00		0.00	0	0		12.00
13. 00		0.00	ol	0		13.00
14. 00		0.00	o	Ö		14.00
15. 00		0. 00	o	Ö		15.00
	TOTALS	— — <del>-                                 </del>		4, 735, 506		
	I - ANESTHESI OLOGY		٩	.,		
1. 00	OPERATING ROOM	50.00	951, 408	29, 056		1.00
	TOTALS	— <del>- 33.</del> 00	951, 408	29, 056		55
500, 00	Grand Total: Increases		1, 394, 194	7, 555, 615		500.00
	1	,				

| Peri od: | Worksheet A-6 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

					To	Time Prepared: 9/2023 10:22 am
		Decreases		<u>'</u>	, , , , , , , , , , , , , , , , , , ,	 
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10.00	
	A - CAFETERIA					
1.00	DI ETARY	10.00	34 <u>4, 9</u> 58	27 <u>0, 8</u> 77	0	1.00
	TOTALS		344, 958	270, 877	'	
	B - EKG					
1.00	RESPI RATORY THERAPY	6500	o	3 <u>5, 1</u> 46	0	1.00
	TOTALS		0	35, 146		
	C - INTEREST					
1.00	INTEREST EXPENSE	11300	0_	489, 517		1.00
	TOTALS		0	489, 517		
	D - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 927, 228	0	1.00
	PATI ENTS					
	TOTALS		0	1, 927, 228	3	
	E - PT OT ST					
1.00	PHYSI CAL THERAPY	66. 00	0	21, 949	0	1.00
2.00		000	0_	0	00	2.00
	TOTALS			21, 949	)	
	F - HHA THERAPIST					
1.00	PHYSI CAL THERAPY	66. 00	45, 780	0	0	1.00
2.00	OCCUPATI ONAL THERAPY	67. 00	15, 570	0	0	2. 00
3.00	SPEECH PATHOLOGY	6800	1, 332	0	0 0	3.00
	TOTALS		62, 682	C	)	
	G - RHC RECRUITING					
1. 00	ADMI NI STRATI VE & GENERAL			8 <u>1, 4</u> 82		1.00
	TOTALS		0	81, 482	2	
	H - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	52, 915	0	1.00
2.00	PHARMACY	15. 00	0	3, 080	0	2. 00
3.00	ADULTS & PEDIATRICS	30. 00	0	59, 721	0	3.00
4.00	INTENSIVE CARE UNIT	31. 00	0	4, 281	0	4.00
5.00	SKILLED NURSING FACILITY	44. 00	0	7, 982	0	5. 00
6. 00	OPERATING ROOM	50. 00	0	2, 615, 132	0	6. 00
7. 00	ANESTHESI OLOGY	53.00	0	43, 290	1	7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	104, 987	1	8. 00
9.00	LABORATORY	60.00	0	1, 597, 013	0	9. 00
10. 00	RESPI RATORY THERAPY	65. 00	0	62, 772	1	10.00
11. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 00	0	100	0	11.00
	SERVI CES					
12. 00	CLINIC	90. 00	0	65, 542	0	12.00
13. 00	PAIN CLINIC	90. 02	0	4	0	13.00
14.00	UROLOGY CLINIC	90. 03	0	32, 567	1	14. 00
15.00	EMERGENCY	<u>91.</u> 00	0_	8 <u>6, 1</u> 20		15. 00
	TOTALS		0	4, 735, 506		
	I - ANESTHESI OLOGY					
1.00	ANESTHESI OLOGY	53.00	951, 408	2 <u>9, 0</u> 56		1.00
	TOTALS		951, 408	29, 056		
500.00	Grand Total: Decreases		1, 359, 048	7, 590, 761		500.00

					From 07/01/2022 To 06/30/2023		pared: : 22 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	449, 428	0		0	424, 428	1.00
2.00	Land Improvements	1, 087, 167	0		0	816, 960	2.00
3.00	Buildings and Fixtures	25, 416, 450	0		0	23, 034, 199	3.00
4.00	Building Improvements	25, 691, 284	0		0	25, 566, 431	4.00
5.00	Fixed Equipment	2, 186, 470	0		0	2, 303, 877	5.00
6.00	Movable Equipment	14, 441, 678	0		0	9, 102, 495	6.00
7.00	HIT designated Assets	0	0		0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69, 272, 477	0		0 0	61, 248, 390	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	69, 272, 477	0		0	61, 248, 390	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	25, 000	0				1.00
2.00	Land Improvements	270, 207	0				2.00
3.00	Buildings and Fixtures	2, 382, 251	0				3.00
4.00	Building Improvements	124, 853	0				4.00
5.00	Fixed Equipment	-117, 407	0				5.00
6.00	Movable Equipment	5, 339, 183	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	8, 024, 087	0				8.00
9.00	Reconciling Items	o	0				9.00
10.00	Total (line 8 minus line 9)	8, 024, 087	0				10.00

Heal th			FAIRFIELD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-1		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 14-1311	Peri od:	Worksheet A-7	
					From 07/01/2022 To 06/30/2023		narod:
					10 00/30/2023	11/29/2023 10	: 22 am
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11. 00	12. 00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				13.00			
1.00	CAP REL COSTS-BLDG & FLXT	2, 737, 567			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	659, 745	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 397, 312	0		0 0	0	3.00
		SUMMARY 0	F CAPI TAL				
	Cost Center Description	Other .	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions) 14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1. 00	CAP REL COSTS-BLDG & FLXT	n Color	2, 737, 567				1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	659, 745	•			2.00
3.00	Total (sum of lines 1-2)	l ő	3, 397, 312	•			3.00
		-	.,,	1			

Health Financial Systems	FAIRFIELD MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2022 To 06/30/2023		pared:
	COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	0.00	col . 2)	4.00	F 00	
DART III DECONCILIATION OF CARLTAL COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS  1.00 CAP REL COSTS-BLDG & FIXT	2, 684, 904		2, 684, 90	0. 334606	0	1. 00
2.00 CAP REL COSTS-BLDG & FIXT	5, 339, 183	l .	2, 684, 90 5, 339, 18			2.00
3.00 Total (sum of lines 1-2)	8, 024, 087		8, 024, 08			3.00
3. 00   10tal (Sum 01 111103 1 2)		TION OF OTHER			F CAPITAL	3.00
	, ALLOON	THOIR OF OTHER	5711 1 171 <u>2</u>	John Her C	1 ON TIME	
Cost Center Description	Taxes	0ther	Total (sum o	f Depreciation	Lease	
·		Capi tal -Rel at	col s. 5	·		
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	C	0		0 2, 293, 761	0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	C	0		0 659, 745		2.00
3.00 Total (sum of lines 1-2)	C	)	IMMARY OF OAR	0 2, 953, 506	0	3. 00
		St	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
oust center beset per on	111101031	(see	instructions			
		instructions)		ed Costs (see		
		ĺ		instructions)	3 ,	
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS						
1.00 CAP REL COSTS-BLDG & FLXT	467, 003	l	1	0	2, 760, 764	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	C	1	1	0	659, 745	2.00
3.00   Total (sum of lines 1-2)	467, 003	S  C	1	0 0	3, 420, 509	3. 00

ADJUST	WENTS TO EXPENSES			Provider CCN. 14-1311	From 07/01/2022 To 06/30/2023	Date/Time Pre	nared:
				Expense Classification o		11/29/2023 10	
			То	From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
1. 00	Investment income - CAP REL	1.00	2. 00 0 CA	3.00 P REL COSTS-BLDG & FLXT	4.00	5. 00 0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2)		OCA	AP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2)	Δ.				- 11	
	Investment income - other (chapter 2)	А	-22, 514 CF	P REL COSTS-BLDG & FIXT	1.00	11	
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		o		0. 00	0	5. 00
6. 00	Rental of provider space by		О		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	-3, 319 AE	MINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	Α	-12, 209 MA	INTENANCE & REPAIRS	6. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		O		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-4, 457, 494			0	10.00
11. 00	Sale of scrap, waste, etc.	В	-584 AD	MINISTRATIVE & GENERAL	5. 00	0	11.00
12. 00		A-8-1	0			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-242, 701 CA	FETERI A	11. 00 0. 00	0	
	and others						
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	patients	_					
18. 00	Sale of medical records and abstracts	В	-12, 240 ME	DICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
00.00	books, etc.)				0.00		00.00
	Vending machines Income from imposition of		0		0. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		О		0. 00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	SPI RATORY THERAPY	65. 00		23. 00
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	ODL	IYSI CAL THERAPY	66. 00		24.00
24.00	therapy costs in excess of	A-0-3	OF1	ITSI CAL ITILINAFI	00.00		24.00
25. 00	limitation (chapter 14) Utilization review -		0 * *	* Cost Center Deleted ***	114. 00		25.00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		O CA	P REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		O CA	AP REL COSTS-MVBLE EQUIP	2. 00	0	27.00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 **	* Cost Center Deleted ***	19.00		28. 00
29. 00	Physicians' assistant	A 0 0	O		0.00	0	29. 00
30. 00	therapy costs in excess of	A-8-3	000	CCUPATI ONAL THERAPY	67. 00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		ΩΔΓ	OULTS & PEDIATRICS	30. 00		30. 99
55. //	i nstructi ons)			o ab//////// 00	33.30		33. //

Heal th	Financial Systems		FAIRFIELD MEMOI	RIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				eri od:	Worksheet A-8	}
				F	rom 07/01/2022 o 06/30/2023		narod:
					0 00/30/2023	11/29/2023 10	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center beserration	(2)	Amount	Cost center	Little "	Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00			0		0. 00	0	32.00
	Depreciation and Interest						
33.00	RECRUI TI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	1 00.00
33. 01	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	PROVI DER TAX	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	DONATI ONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	VERI ZON RENTAL	A		CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33. 05 33. 06	WAYFAIR RENTAL LOBBYING	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 05 33. 06
33.06	OTHER REVENUE	A B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33.06
33. 07	REBATES	l B		CENTRAL SERVICES & SUPPLY	14. 00	0	33.07
33. 09	RHC HOSPITALIST	A A		RURAL HEALTH CLINIC	88. 00	0	33.09
33. 10	RHC HOSPITALIST BENEFITS	Ä		EMPLOYEE BENEFITS DEPARTMENT		0	33. 10
33. 11	RINARD & WEBER CLINIC	Ä		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 11
33. 12	ANESTHESI OLOGY EXPENSE	Ä		OPERATING ROOM	50.00	Ó	33. 12
33. 12		, ,	0		0.00	n	33. 13
	(3)				0.00		
50.00			-8, 478, 861				50.00
	/Torriginal Control World Street A	I		l .	1		1

(Transfer to Worksheet A, column 6, line 200.)

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
 1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	G	DSSI	15. 00 DSSI	15. 00	6. 00
7.00			0. 00	0.00	7. 00
8.00			0. 00	0.00	8. 00
9.00			0. 00	0.00	9. 00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Worksheet A-8, column 2,

line 12.

- 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.
- 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
- 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 provi der.

Heal th	Financial Syste	ems	FAIR	FIELD MEMORIA	L HOSPITAL	L	In Lieu	of Form CMS-	2552-10
STATEM OFFICE		SERVICES FROM	RELATED ORGANIZATIO	ONS AND HOME	Provi der	CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet A-8 Date/Time Pro 11/29/2023 10	epared:
	Net Adjustments (col. 4 minus col. 5)* 6.00	Wkst. A-7 Ref. 7.00							
	A. COSTS INCURI OFFICE COSTS:	RED AND ADJUST	MENTS REQUIRED AS A	RESULT OF TRA	ANSACTI ONS	S WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
1. 00 2. 00 3. 00 4. 00 5. 00	0 0 0 0	10 0 0 0							1.00 2.00 3.00 4.00 5.00
appropi	iate. Positive a	amounts increas	bscripts as appropri se cost and negative columns 1 and/or 2,	amounts decr	ease cost	. For related o	rganization or ho	me office cos	
	Rel ated Orga and/or Ho							·	
	Type of								

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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	MRI	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

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

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

- 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 organi zati on.
- 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

Peri od: Worksheet A-8-2
From 07/01/2022
To 06/30/2023 Date/Time Prepar Provi der CCN: 14-1311

With the content   With the co								To 06/30/2023	Date/Time Pre	
Identifier   Remuneration   Component   Component   Identification   Component   Component   Identification   Component   Component   Identification   Component   Identification   Component   Identification   Component   Identification   Component   Identification   Component   Component   Identification   Component   Component   Identification   Component   Com		Wkst. A Line #	Cost Center/Physician	Total	Pro	fessi onal	Provi der	RCE Amount		
1.00				Remuneration	Co	omponent	Component		ider Component	
1.00   30.00ADULTS & PEDIATRICS   289, 927   289, 927   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						·	•		Hours	
2.00		1.00	2.00	3. 00		4. 00	5. 00	6.00	7. 00	
3.00	1.00	30.00	ADULTS & PEDIATRICS	289, 927	,	289, 927	C	0	0	1.00
A 00	2.00	50.00	OPERATING ROOM	99, 788	3	99, 788	S C	0	0	2.00
5.00	3.00	69. 00	ELECTROCARDI OLOGY	35, 146	,	35, 146	o c	0	0	3.00
Continuing   Con	4.00	90.00	CLINIC	1, 328, 504	ı	1, 328, 504	c	0	0	4.00
7.00	5.00	90. 03	UROLOGY CLINIC	820, 897	·	820, 897	' C	0	0	5.00
7.00	6.00	91.00	EMERGENCY	2, 227, 886	,	1, 883, 232	344, 654	. 0	0	6.00
9.00	7.00	0.00		0		O		0	0	7.00
1.00	8.00	0.00		0		C	) .	0	0	8. 00
Number   N	9. 00	0.00		0		C	) .	0	0	9. 00
Number   N	10.00	0.00		0		0		0	0	10.00
Wkst. A Line #   Cost Center/Physician I dentifier   Linit   Linit   Linit   Component   Cost of General Physician Cost of Malpractice   Linit   Component   Com				4, 802, 148	3	4, 457, 494	344, 654		0	
Identifier		Wkst. A Line #	Cost Center/Physician						Physician Cost	
1.00							Memberships &	Component		
1.00						,				
1.00							Educati on	12		
2. 00		1.00	2. 00	8. 00		9. 00	12.00	13. 00	14. 00	
3. 00	1. 00	30.00	ADULTS & PEDIATRICS	0	)	C	) C	0	0	1.00
4. 00 90. 00 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	50.00	OPERATING ROOM	0		0	0	0	0	2.00
S. 00	3.00	69. 00	ELECTROCARDI OLOGY	0		0	0	0	0	3.00
6. 00	4.00	90.00	CLINIC	0		0	0	0	0	4.00
7.00	5.00	90. 03	UROLOGY CLINIC	0		0	0	0	0	5.00
8. 00	6.00	91.00	EMERGENCY	0		0	0	0	0	6.00
9.00	7.00	0.00		0		0	0	0	0	7.00
10.00	8.00	0.00		0		0	0	0	0	8.00
Number   Cost Center/Physician   Identifier   Component   Share of col.   14	9.00	0.00		0		0	0	0	0	9. 00
Wkst. A Line # Cost Center/Physician I dentifier   Provider Component Share of col.   14	10.00	0.00		0		0	0	0	0	10.00
Identifier   Component Share of col.   Li mi t   Di sal I owance	200.00			0		0	0	0	0	200.00
Share of col.   14		Wkst. A Line #	Cost Center/Physician	Provi der	Adj	usted RCE	RCE	Adjustment		
14			I denti fi er	Component		Limit	Di sal I owance	_		
1. 00         2. 00         15. 00         16. 00         17. 00         18. 00           1. 00         30. 00 ADULTS & PEDI ATRI CS         0         0         0         289, 927         1. 00           2. 00         50. 00 OPERATI NG ROOM         0         0         0         99, 788         2. 00           3. 00         69. 00 ELECTROCARDI OLOGY         0         0         0         35, 146         3. 00           4. 00         90. 00 CLI NI C         0         0         0         1, 328, 504         4. 00           5. 00         90. 03 UROLOGY CLI NI C         0         0         0         820, 897         5. 00           6. 00         91. 00 EMERGENCY         0         0         0         1, 883, 232         6. 00           7. 00         0         0         0         0         0         7. 00           8. 00         0         0         0         0         0         9. 00           9. 00         0         0         0         0         9. 00           10. 00         0         0         0         0         9. 00				Share of col.						
1. 00         30. 00 ADULTS & PEDI ATRI CS         0         0         289, 927         1. 00           2. 00         50. 00 OPERATI NG ROOM         0         0         0         99, 788         2. 00           3. 00         69. 00 ELECTROCARDI OLOGY         0         0         0         35, 146         3. 00           4. 00         90. 00 CLI NI C         0         0         0         1, 328, 504         4. 00           5. 00         90. 03 UROLOGY CLI NI C         0         0         0         820, 897         5. 00           6. 00         91. 00 EMERGENCY         0         0         0         1, 883, 232         6. 00           7. 00         0. 00         0         0         0         0         7. 00           8. 00         0. 00         0         0         0         0         8. 00           9. 00         0. 00         0         0         0         0         9. 00           10. 00         0         0         0         0         0         9. 00										
2. 00     50. 00 OPERATING ROOM     0     0     99, 788     2. 00       3. 00     69. 00 ELECTROCARDI OLOGY     0     0     0     35, 146     3. 00       4. 00     90. 00 CLI NI C     0     0     0     1, 328, 504     4. 00       5. 00     90. 03 UROLOGY CLI NI C     0     0     0     820, 897     5. 00       6. 00     91. 00 EMERGENCY     0     0     0     1, 883, 232     6. 00       7. 00     0. 00     0     0     0     0     7. 00       8. 00     0. 00     0     0     0     0     8. 00       9. 00     0. 00     0     0     0     0     9. 00       10. 00     0     0     0     0     0     0     9. 00				15. 00						
3. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 35, 146 3. 00 4. 00 90. 00 CLI NI C 0 0 0 0 1, 328, 504 4. 00 5. 00 90. 03 UROLOGY CLI NI C 0 0 0 820, 897 5. 00 6. 00 91. 00 EMERGENCY 0 0 0 0 1, 883, 232 6. 00 7. 00 0 0 0 0 0 7. 00 8. 00 9. 00 0 0 0 0 8. 00 9. 00 0 0 0 0 9. 00 9.				0						
4. 00     90. 00 CLINIC     0     0     1, 328, 504     4. 00       5. 00     90. 03 UROLOGY CLINIC     0     0     0     820, 897     5. 00       6. 00     91. 00 EMERGENCY     0     0     0     1, 883, 232     6. 00       7. 00     0. 00     0     0     0     0     7. 00       8. 00     0. 00     0     0     0     0     8. 00       9. 00     0. 00     0     0     0     0     9. 00       10. 00     0. 00     0     0     0     0     10. 00				0		_	1	777700		
5. 00         90. 03 UROLOGY CLINIC         0         0         820, 897         5. 00           6. 00         91. 00 EMERGENCY         0         0         0         1, 883, 232         6. 00           7. 00         0. 00         0         0         0         0         7. 00           8. 00         0. 00         0         0         0         0         8. 00           9. 00         0. 00         0         0         0         0         9. 00           10. 00         0. 00         0         0         0         0         10. 00				0						
6. 00 91. 00 EMERGENCY 0 0 0 1,883,232 6. 00 7. 00 0 0 0 0 7. 00 8. 00 0 0 0 0 8. 00 9. 00 0 0 0 9. 00 9. 00 0 0 9. 00 10				0		-	_	.,,		
7. 00         0. 00         0         0         0         7. 00           8. 00         0. 00         0         0         0         0         8. 00           9. 00         0. 00         0         0         0         0         9. 00           10. 00         0         0         0         0         0         10. 00				0						
8. 00     0. 00       9. 00     0. 00       10. 00     0. 00         0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0		•		0	)	-	_		1	
9. 00 0. 00 0 0 0 9. 00 10. 00 0 0 10. 00				0					1	
10.00 0.00 0 0 0 10.00				0	)	-	_	1		
		•		0	)			-		
		0.00		0	)	-	1	1	1	
200.00   0 0 4,457,494   200.00	200.00	1		0	)	O	)  C	4, 457, 494		200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2022 | Part | | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 14-1311

Cost Center Description					To	06/30/2023	Date/Time Pre	pared:
GENERAL SERVICE COST CENTERS				CAPI TAL REI	LATED COSTS		11/29/2023 10	: 22 am
GENERAL SERVICE COST CENTERS		Cook Cooker December 1	Nat Francisco	DIDC & FLVT	MANDLE FOLLID	EMDL OVEE	Ch. + - + - 1	
CALL DOCATION   COLOR   CENTERS   CENT		cost center bescription		BLDG & FIXI	MARTE ECOLA		Subtotal	
COL. 77								
CEMPRAL SERVICE COST CENTERS   0   1.00   2.00   4.00								
FINERAL SERVICE COST CENTERS				1 00	2 00	4 00	4A	
2.00			-					
4.00   0.0000   EMPLOYEE BENEFITS DEPARTMENT   5, 250, 450   0.0000   0.0000   MINISTRATIVE & GENERAL   4, 554, 720   419, 738   100, 306   573, 430   5, 648, 194   5, 00   6.000   0.0000   MINISTRATIVE & GENERAL   4, 554, 720   419, 738   100, 306   573, 430   1, 002, 803   6.00   7.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		1 1		2, 760, 764				
5.00   00500   ADMIN STRATIVE & CERREAL   4,554,720   419,738   100,306   573,430   5,648,194   5.00   0.00   00000   UNITEMANCE & REPAIRS   819,373   51,000   12,001   12,001   1,002,306   6.00   0.00   00000   CURRENT   869,546   31,324   7,486   0   908,356   7.00   0.00   00000   DETARTY   869,546   31,324   7,486   0   589,440   8.00   0.00   00000   DETARRY   361,095   2,217   5.30   48,834   412,676   10.00   11.00   01000   DETARRY   373,134   65,136   6,136   6,136   6,136   6,136   6,136   11.00   01000   DETARRY   373,134   6,136   6,136   6,136   6,136   6,136   11.00   01000   DETARRY   373,134   6,136   6,136   6,136   6,136   12.00   00000   DETARRY   373,134   6,136   6,136   6,136   6,136   13.00   03000   DETARRY   373,134   6,136   6,136   6,136   6,136   13.00   03000   DETARRY   373,134   6,136   6,136   6,136   6,136   13.00   03000   DETARRY   373,134   6,136   6,136   6,136   6,136   6,136   13.00   03000   DETARRY   373,134   6,136   6,136   6,136   6,136   6,136   6,136   13.00   03000   DETARRY   374,134   6,136				0		5 256 450		
7, 00         00 0700 (DPERATION OF PLANT         869, 546         31, 324         7, 486         0         908, 356         7, 00           8, 00         00 0800 (LANIORY & LINEW SERVICE         560, 624         21, 644         5, 172         0         587, 40         8, 00           9, 00         00 0900 (HOUSEKEEPING         842, 149         16, 280         3, 890         16, 97, 51         1, 032, 070         9, 00           11, 00         01 000 (DETARY)         361, 095         2, 217         530         48, 834         412, 676         10, 00         10           11, 00         01 100 (CAFETERI A         373, 3134         65, 136         15, 566         83, 266         537, 122         11, 10           14, 00         01 1400 (CENTRAL SERVICES & SUPPLY         93, 499         0         0         73, 683         2, 158, 130         15, 50           16, 00         01600 (MEDICAL RECORDS & LIBRARY         499, 741         24, 927         5, 957         93, 272         623, 897         16, 00           16, 00         01600 (MEDICAL RECORDS & LIBRARY         299, 444         24, 27, 78         647         33, 216         178, 586         17, 70           16, 00         01600 (MEDICAL RECORDS & LIBRARY         499, 741         24, 927         5							5, 648, 194	
0.000   0.0000   LAUNDRY & LINEN SERVICE   560, 624   21, 644   5, 172   0   587, 440   8, 00   0.000   0.000   DIETARY   361, 095   2, 217   530   48, 834   412, 676   10, 00   10.00   10.00   0.000   DIETARY   361, 095   2, 217   530   48, 834   412, 676   10, 00   13.00   0.000   DIETARY   373, 134   651, 136   15, 666   83, 886   537, 122   11, 00   13.00   0.000   CAFETERI A   13.00   0.0000   0.000   0.000   0.00000   0.00000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		1 1						1
9.00   09000   HOUSEKEPING   542,149   16,280   3,890   169,751   1,032,070   9,00   11.00   01000   DITARY   361,095   2,217   530   48,843   412,676   10.00   11.00   01000   CAFETERI A   373,134   65,136   15,566   83,286   537,122   11.00   14.00   01400   CAFETERI A   373,134   65,136   15,566   83,286   537,122   11.00   14.00   01400   CAFETERI A   58,000   0.00   0.00   0.00   0.00   14.00   01400   CENTRAL SERVICES & SUPPLY   93,499   0.00   0.00   73,683   2,158,130   15.00   16.00   01600   MEDICAL RECORDS & LIBRARY   499,741   24,927   5,957   93,272   623,897   16.00   16.00   01600   MEDICAL RECORDS & LIBRARY   499,741   24,927   5,957   93,272   623,897   16.00   17.00   01700   03000   AURILS & PEDIATRICS   2,131,407   322,042   76,959   386,821   2,917,229   18.00   03000   AURILS & PEDIATRICS   2,131,407   322,042   76,959   386,821   2,917,229   31.00   13.00   03000   SINLED MINSIN SEAULITY   1,231,275   267,466   63,917   272,761   1,835,422   44.00   14.00   44000   SHILED MINSIN SEAULITY   1,231,275   267,466   63,917   272,761   1,835,422   44.00   14.00   SANDON   1,838,595   232,402   55,538   296,544   2,423,079   15.00   05000   PERATING KROM   1,970,489   77,473   18,514   212,057   2,798,532   54.00   15.00   05000   PERATING KROM   1,970,489   77,473   18,514   212,057   2,798,532   54.00   15.00   05000   RESPIRATORY THERAPY   255,742   31,730   7,583   54,495   349,550   65.00   15.00   05000   PERATING KROM   1,970,489   77,473   14,249   3,405   48,108   280,679   67.00   15.00   05000   PERATING KROM   1,971,278   77,000   70,000   7,000   70,000   15.00   05000   PERATING KROM   1,971,278   77,000   70,0						_		1
10.00   01000   DIETARY   361,095   2,217   550   48,834   412,676   10.00     10.00   01000 CAFETERIA N INSTRATION   480,718   4.028   962   102,131   587,839   13.00     10.00   01000 CENTRAL SERVICES & SUPPLY   93,499   0   0   0   73,663   2,158,130     15.00   01500 PHARMACY   2,084,447   0   0   0   73,663   2,158,130     15.00   01500 PHARMACY   2,084,447   0   0   0   73,663   2,158,130     17.00   01700 MEDICAL RECORDS & LIBRARY   499,711   24,927   5,957   93,272   623,897   16.00     17.00   01700 MEDICAL RECORDS & LIBRARY   499,711   24,927   5,957   93,272   623,897   16.00     17.00   01700 MEDICAL RECORDS & LIBRARY   499,711   24,927   5,957   93,272   623,897   16.00     18.00   10100 MEDICAL RECORDS & LIBRARY   499,711   24,927   5,957   93,272   623,897   16.00     18.00   10100 MEDICAL RECORDS & LIBRARY   499,711   24,927   5,957   93,272   623,897   16.00     18.00   10100 MEDICAL RECORDS & LIBRARY   499,711   24,927   5,957   93,272   623,897   16.00     18.00   10100 MITKENI WE CARE UNIT   20,704   22,558   5,391   4,706   53,409   310.00     18.00   10100 MITKENI WE CARE UNIT   2,0704   22,558   5,391   4,706   53,409   310.00     18.00   10100 MITKENI WE CARE UNIT   2,0704   22,558   5,391   4,706   53,409   310.00     18.00   05000   0FERAITING ROOM   1,838,595   232,402   55,538   296,544   2,423,079   50.00     18.00   05000   0FERAITING ROOM   1,838,595   232,402   55,538   296,544   2,12,677   60.00     18.00   05000   0FERAITING ROOM   1,970,488   77,473   18,514   212,057   2,278,532   54.00     18.00   05000   0FERAITING ROOM   1,970,488   77,473   18,514   212,057   2,278,532   54.00     18.00   05000   0FERAITING RECORD RESORTING RECORD RESORTING RECORD RESORTING RESORTIN						-		1
13.00   01300 NURSIN & ADMINI STRATION   480, 718   4,028   962   102, 131   587, 839   31,00   15.00   01500 PHARMACY   2,084,447   0 0 0 73,683   2,186,130   15.00   15.00   01500 PHARMACY   49,971   24,927   5,957   93,272   6623,897   16.00   17.00   01700 SOCIAL SERVICE   COST CENTERS   142,015   2,708   647   33,216   178,586   17.00   17.0								1
14. 00   01400   CENTRAL SERVICES & SUPPLY   93, 499   0   0   22, 090   115, 589   14. 00		1						1
15.00   01500   PHAMMACY   2, 084, 447   0   0   73, 663   2, 158, 130   15.00					l l			
16.00   01600   MEDICAL RECORDS & LIBRARY   499, 741   24, 927   5, 957   93, 272   623, 897   16.00				_				1
INPATI ENT ROUTINE SERVICE COST CENTERS   2,131,407   322,042   76,959   386,821   2,917,229   30.00   31.00				_	I -			
30.00   03000   ADULTS & PEDIATRICS   2,131,407   322,042   76,959   386,821   2,917,229   30.00   30.00   30.00   INTENSINE CARE UNIT   20,704   22,558   5,391   4,796   53.449   31.00	17. 00		142, 015	2, 708	647	33, 216	178, 586	17. 00
11 00	20.00		2 121 407	222 042	7/ 050	207 021	2 017 220	20.00
A. O.								1
ANCILLARY SERVICE COST CENTERS		1 1						1
53.00   05300   ARSTHESI OLOGY   0   0   0   0   0   53.00								
54 00   05400   RADI OLOGY-DI AGNOSTIC   1, 970, 48B   77, 473   18, 514   212, 057   2, 278, 532   54. 00   0600   0.0								
60 00   06000   LABORATORY   1, 797, 586   43, 136   10, 308   264, 647   2, 115, 677   60.00						-		
66.00   06600   PHYSICAL THERAPY   824, 767   64, 121   15, 323   182, 109   1, 086, 320   66.00   67.00   06700   OCCUPATI ONAL THERAPY   214, 917   14, 249   3, 405   48, 108   280, 679   67.00   68.00   06800   SPEECH PATHOLOGY   120, 960   5, 720   1, 367   27, 686   155, 736   68.00   69.00   06800   SPEECH PATHOLOGY   0 0 0 0   0 8, 486   8, 486   69.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   2, 808, 278   33, 321   7, 963   0 0   2, 849, 562   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   1, 927, 228   0 0 0 0   0   1, 927, 228   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   55, 829   13, 341   0   69, 170   73.00   07300   DRUGS CHARGED TO PATIENTS   0   55, 829   13, 341   0   69, 170   74.00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   77.00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   88.00   08800   RURAL HEALTH CLINIC   4, 479, 691   528, 705   126, 345   1, 023, 245   6, 157, 986   88.00   08800   RURAL HEALTH CLINIC   4, 479, 691   528, 705   126, 345   1, 023, 245   6, 157, 986   89.00   09000   CLINIC   732, 165   195, 104   46, 624   466, 628   1, 440, 521   90.00   90.01   09000   DUNID CARE   0   0   0   0   0   0   90.02   09002   PAIN CLINIC   248, 936   0   0   0   30, 615   279, 551   90.02   90.03   09003   URLOGY CLINIC   220, 544   78, 878   18, 850   244, 468   562, 740   90.03   91.00   09100   EMERGENCY   1, 631, 470   87, 085   20, 811   262, 777   2, 002, 143   91.00   93.99   09399   PARTIAL HOSPITALIZATION PROGRAM   0   0   0   0   0   0   95.00   91.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   92.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   92.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   93.99   07500   AMBULANCE SERVICES   0   0   0   0   0   0   94.00   07500   07		06000 LABORATORY						1
67:00   06700   05CUPATI ONAL THERAPY   214, 917   14, 249   3, 405   48, 108   280, 679   67. 00   68. 00   06900   SPECH PATHOLOGY   120, 960   5, 720   1, 367   27, 686   155, 733   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   8, 486   8, 486   69. 00   071. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   2, 808, 278   33, 321   7, 963   0   2, 849, 562   71. 00   72. 00   10PL DEV. CHARGED TO PATI ENTS   2, 808, 278   33, 321   7, 963   0   0, 1, 927, 228   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   55, 829   13, 341   0   69, 170   73. 00   76. 00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   318, 034   29, 361   7, 016   47, 881   402, 292   76. 00   77. 00   00   0   0   0   0   0   0   0								1
68. 00   06800   SPECH PATHOLOGY   120, 960   5, 720   1, 367   27, 686   155, 733   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0 0 0 0   8, 486   8, 486   69. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   2, 808, 278   33, 321   7, 963   0 2, 849, 562   71. 00   72. 00   72. 01   MPL DEV. CHARGED TO PATI ENTS   1, 927, 228   0 0 0 0 0   1, 927, 228   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0 55, 829   13, 341   0 0   69, 170   73. 00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   318, 034   29, 361   7, 016   47, 881   402, 292   76. 00   77. 00   0700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0 0 0 0 0 0 0 0   0 0   0   0   0								
69.00   06900   ELECTROCARDIOLOGY   0   0   0   8,486   8,486   69.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   2,808,278   33,321   7,963   0   2,849,562   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   1,927,228   0   0   0   0   1,927,228   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   1,927,228   0   0   0   0   0   76.00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES   318,034   29,361   7,016   47,881   402,292   76.00   77.00   0700   ALDOGENIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   77.00   0700   ALDOGENIC STEM CELL ACQUISITION   0   0   0   0   0   0   77.00   0700   ALDOGENIC STEM CELL ACQUISITION   0   0   0   0   0   78.00   08800   RURAL HEALTH CLINIC   4,479,691   528,705   126,345   1,023,245   6,157,986   80.00   79.01   09001   WOUND CARE   0   0   0   0   0   0   0   79.02   09002   PAIN CLINIC   248,936   0   0   0   0   0   0   79.03   09003   WOLOGY CLINIC   2220,544   78,878   18,850   224,468   562,740   90.03   79.00   09003   WOLOGY CLINIC   2220,544   78,878   18,850   244,468   562,740   90.03   79.00   09200   DESERVATION BEDS (NON-DISTINCT PART)   0   92.00   79.00   09500   ABBULANCE SERVICES   0   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HER REIMBURSABLE COST CENTERS   0   0   0   0   0   70   07HORE IMBURSABLE COST CENTERS   0   0   0   0   0   70   07HORE IMBURSABLE COST CENTERS   0   0   0   0   0   70   07HORE IMBURSABLE COST CENTERS   0   0   0   0   0   0   70   07HORE IMBURSABLE COST CENTERS   0   0   0   0   0   0   70   07HORE IMBURSABLE COST CENTERS   0   0   0   0   0   0   0   70   07HORE IMBURSABLE COST CENTERS   0   0   0   0   0								1
72. 00   07200   IMPL   DEV. CHARGED TO PATIENTS   1,927,228   0   0   0   1,927,228   72. 00   73. 00   7300   DRUGS CHARGED TO PATIENTS   0   55,829   13,341   0   69,170   73. 00   73. 00   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   318,034   29,361   7,016   47,881   402,292   76. 00   77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   0   0			0	0	0			1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   55,829   13,341   0   69,170   73.00   76.00   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   318,034   29,361   7,016   47,881   402,292   76.00   77.00   0700   ALLOGENEIC STEM CELL ACQUI SITION   0   0   0   0   0   0   0   0   0				33, 321		-		
76. 00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   318, 034   29, 361   7, 016   47, 881   402, 292   76. 00   0   0   0   0   0   0   0   77. 00   0   0   0   0   0   0   0   0   0			1, 927, 228	55 920				1
77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   0   0			318, 034			٩		1
88. 00	77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION						
90. 00	00.00		4 470 (04	500 705	10/ 045	4 000 045	( 457.00/	00.00
90. 01								1
90. 03			732, 103			400, 020		
91. 00				0	I -	·		1
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   92. 00   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   0   0   93. 99   07HER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0								1
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   0   0   93. 99		1 1	1,631,470	87,085	20, 811	262, 777		
95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   95. 00   101. 00   10100   HOME HEALTH AGENCY   525, 962   32, 492   7, 765   102, 499   668, 718   101. 00   102. 00   10200   OPI 0I D   TREATMENT PROGRAM   0   0   0   0   0   0   SPECIAL PURPOSE COST CENTERS  113. 00   SUBTOTALS (SUM OF LINES 1 through 117)   43, 656, 769   2, 760, 764   659, 745   5, 256, 450   43, 656, 769   118. 00   NONREI MBURSABLE COST CENTERS  192. 00   19200   PHYSI CI ANS'   PRI VATE OFFICES   66   0   0   0   66   192. 00   200. 00   Cross Foot Adjustments   0   200. 00			0	0	o	О		
101. 00		OTHER REIMBURSABLE COST CENTERS						
102. 00								
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   SUBTOTALS (SUM OF LINES 1 through 117)   43,656,769   2,760,764   659,745   5,256,450   43,656,769   118.00   NONREI MBURSABLE COST CENTERS   192.00   19200   PHYSI CI ANS' PRI VATE OFFICES   66   0   0   0   66   192.00   200.00   Cross Foot Adjustments   0   200.00   0   0   0   0   0   0   0   0			525, 962	32, 492		102, 499		
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 43, 656, 769 2, 760, 764 659, 745 5, 256, 450 43, 656, 769 118. 00 NONREI MBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 66 0 0 0 66 192. 00 200. 00 Cross Foot Adjustments 0 200. 00	102.00				, o	<u> </u>		102.00
NONREI MBURSABLE COST CENTERS   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   66   0   0   66   192.00   200.00   Cross Foot Adjustments   0   200.00								
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 66 0 0 0 66 192.00 200.00 Cross Foot Adjustments 6 0 200.00	118.00		43, 656, 769	2, 760, 764	659, 745	5, 256, 450	43, 656, 769	J118. 00
200.00   Cross Foot Adjustments   0 200.00	192. 00		66	Ω	O	ol	66	192.00
201.00   Negative Cost Centers     0   0   0   201.00	200.00	Cross Foot Adjustments				اً ا	0	200. 00
	201.00		40 (5) 05=	0 7/2 7:	- T	-		
202.00   TOTAL (sum lines 118 through 201)   43,656,835   2,760,764   659,745   5,256,450   43,656,835   202.00	202.00	म् । TUTAL (sum lines 118 through 201)	43, 656, 835	2, 760, 764	659, /45	5, 256, 450	43, 656, 835	J202.00

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

				1	0 00/30/2023	11/29/2023 10	
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 648, 194	l e				5. 00
6. 00	00600 MAINTENANCE & REPAIRS	149, 020	1, 151, 823				6. 00
7. 00	00700 OPERATION OF PLANT	134, 984	15, 756	1, 059, 096			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	87, 295	10, 887	10, 149	695, 771		8. 00
9. 00	00900 HOUSEKEEPI NG	153, 369	8, 189	7, 634	197, 102	1, 398, 364	9.00
10.00	01000 DI ETARY	61, 325	l	1, 040	8, 016	l	1
11. 00	01100 CAFETERI A	79, 818	32, 763		0	41, 016	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	87, 355	2, 026	1, 889	0	2, 536	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	17, 177	0	0	0	0	14.00
15.00	01500 PHARMACY	320, 705	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	92, 713	12, 538	11, 689	0	15, 697	16. 00
17. 00	01700 SOCI AL SERVI CE	26, 538	1, 362	1, 270	0	1, 705	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	433, 509	l		128, 041	202, 790	1
31.00	03100 I NTENSI VE CARE UNI T	7, 943	l			14, 205	1
44.00	04400 SKILLED NURSING FACILITY	272, 749	134, 534	125, 419	89, 307	168, 423	44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	360, 077	116, 897	108, 977	96, 430	146, 343	1
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	338, 597	38, 968	1	38, 758	1	1
60.00	06000 LABORATORY	314, 396	21, 697	20, 227	9, 600	, , , , ,	1
65.00	06500 RESPI RATORY THERAPY	51, 944			5, 217	1	1
66. 00	06600 PHYSI CAL THERAPY	161, 430	1		8, 814		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	41, 710	l		1, 953		1
68. 00	06800 SPEECH PATHOLOGY	23, 142	2, 877	2, 682	786	3, 602	1
69. 00	06900 ELECTROCARDI OLOGY	1, 261	0	1	0	-	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	423, 453	16, 760	15, 625	0	20, 982	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	286, 392	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 279	1	26, 179	0	35, 155	1
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	59, 782	14, 768	1	0		1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	0.45 0.00	0.5.007		40.000	200 000	
88. 00	08800 RURAL HEALTH CLINIC	915, 090	1	1	13, 209	332, 923	88.00
90.00	09000 CLINIC	214, 066	1	1	0	,	90.00
90. 01	09001 WOUND CARE	0	0	0	0	0	90. 01
90. 02	09002 PAIN CLINIC	41, 542	0	0	0	0	90.02
90. 03	09003 UROLOGY CLINIC	83, 625	39, 675	1	00 500	49, 669	1
91.00	09100 EMERGENCY	297, 524	43, 803	40, 835	98, 538	54, 837	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	0	93. 99
05 00	OTHER REIMBURSABLE COST CENTERS			1 0	٥		05.00
	09500 AMBULANCE SERVICES	0 274			0		
	10100 HOME HEALTH AGENCY	99, 374	1	1			101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE			1			113.00
118.00		F 440 104	1 151 000	1 050 004	40E 771	1 200 244	
118.00		5, 648, 184	1, 151, 823	1, 059, 096	695, 771	1, 398, 364	1118.00
102.00	NONREIMBURSABLE COST CENTERS   19200   PHYSICIANS' PRIVATE OFFICES	10	0	0	0		102 00
	1 1	10	١	ı o	ا ا	l	192.00
200.00		0	,		0	_	200. 00 201. 00
201. 00 202. 00		5, 648, 194	1	1	695, 771	l	
202. UC	TOTAL (Sum Times 110 through 201)	5,040,194	1, 151, 823	1,009,090	090, 771	1, 370, 304	1202.00

Peri od: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/29/2023 10: 22 am

						11/29/2023 10	: 22 am
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10. 00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1. 00 2. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						6. 00 7. 00 8. 00 9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	485, 568 0	721, 262				10. 00 11. 00
13. 00 14. 00	O1300   NURSING ADMINISTRATION   O1400   CENTRAL SERVICES & SUPPLY	0	18, 752 5, 381	700, 397 0	138, 147		13. 00 14. 00
15. 00 16. 00 17. 00	01500  PHARMACY   01600  MEDI CAL RECORDS & LI BRARY   01700  SOCI AL SERVI CE	0 0 0	9, 536 24, 585 5, 674	0 0 0	913 240 7	2, 489, 284 0 0	15. 00 16. 00 17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	400.004	04 055	100 ((0)	4 04 (		
30. 00 31. 00	03000 ADULTS & PEDIATRICS	122, 021	81, 055 107	193, 668 226	1, 316 20	0	
	03100 I NTENSI VE CARE UNIT 04400 SKI LLED NURSI NG FACILITY ANCI LLARY SERVI CE COST CENTERS	4, 968 358, 579	79, 110		1, 934	0	
50.00	05000 OPERATING ROOM	0	52, 820	126, 225	8, 415	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	53, 513		477	0	54.00
60.00	06000 LABORATORY	0	88, 859		2, 031	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	11, 320		309	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	31, 910		787	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	7, 458 2, 877		0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	2, 184		0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 104	0	66, 572	0	I
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0	Ö	45, 689	0	72.00
	1 1	o	0	Ö	0	2, 489, 284	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	10, 734	0	123	0	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
88.00	08800 RURAL HEALTH CLINIC	0	103, 936	0	5, 674	0	88. 00
90. 00 90. 01	09000   CLI NI C   09001   WOUND   CARE	0	37, 451 0	0	1, 194 0	0	90. 00 90. 01
90. 02	09002 PAIN CLINIC	0	8, 231	0	15	0	90. 02
90. 03	09003 UROLOGY CLINIC	0	22, 854		320	0	90. 03
91. 00	09100 EMERGENCY	0	62, 915	150, 334	1, 502	0	91.00
92. 00 93. 99	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   O9399   PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	92. 00 93. 99
05 00	OTHER REIMBURSABLE COST CENTERS	ما	0		ما	0	05.00
	09500 AMBULANCE SERVICES	0	0		0	0	
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	0	0		607 0		101. 00 102. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300   NTEREST EXPENSE				1		113. 00
118. 00		485, 568	721, 262	700, 397	138, 145	2, 489, 284	
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	2	0	192. 00
200.00			_		7	_	200.00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	485, 568	721, 262	700, 397	138, 147	2, 489, 284	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	FAIRFIELD MEMORI	Provi der CC	N: 14-1311	Peri od:	worksheet B	2002 10
					From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/29/2023 10	epared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	7. 22 diii
		16. 00	17. 00	24.00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	701 250					15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	781, 359	215 142				16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	215, 142				17.00
30. 00		19, 394	116, 557	4, 528, 5	75 0	4, 528, 575	30.00
31. 00		939	0	103, 7		103, 782	
44.00	04400 SKILLED NURSING FACILITY	8, 339	98, 585	3, 361, 3		3, 361, 390	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	146, 459	0	3, 585, 7		3, 585, 722	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	170, 117	0	3, 004, 0		3, 004, 075	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	137, 677 22, 624	0	2, 737, 3 491, 7		2, 737, 327 491, 784	
66.00	06600 PHYSI CAL THERAPY	19, 510	0	1, 411, 4		1, 411, 467	1
67.00	06700 OCCUPATI ONAL THERAPY	4, 335	o	358, 9		358, 957	
68. 00	06800 SPEECH PATHOLOGY	1, 741	o	193, 4		193, 440	1
69.00	06900 ELECTROCARDI OLOGY	9, 782	0	21, 7		21, 713	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 097	0	3, 458, 0	51 0	3, 458, 051	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	47, 708	0	2, 307, 0		2, 307, 017	
73. 00	07300 DRUGS CHARGED TO PATIENTS	41, 636	0	2, 699, 7		2, 699, 784	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	6, 886	0	526, 8		526, 842	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
00 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	28, 488	0	0 071 1	59 0	0 071 1E0	88.00
	09000 CLINIC	4, 464	0	8, 071, 1 2, 010, 1		8, 071, 159 2, 010, 176	
	09001 WOUND CARE	4, 404	0	2,010,1	0 0		90.00
	09002 PAIN CLINIC	726	ő	330, 0	65 0	330, 065	
	09003 UROLOGY CLINIC	4, 070	ol	799, 9		799, 940	
	09100 EMERGENCY	41, 367	O	2, 793, 7		2, 793, 798	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		ĺ		0		92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0 0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS	1					
	09500 AMBULANCE SERVI CES	0	0		0 0		95.00
	0 10100 HOME HEALTH AGENCY 0 10200 OPIOID TREATMENT PROGRAM	0	0	861, 6	93 0	861, 693	101.00 102.00
1117 (16		1 (1)					

0

781, 359

781, 359

43, 656, 757 118. 00

43, 656, 835 202. 00

0 102.00

78 192. 00

0 200.00

0 201.00

113. 00

0 0 0

43, 656, 757

43, 656, 835

78

0

215, 142

215, 142

200.00

201.00

202.00

102.00 10200 OPI OI D TREATMENT PROGRAM

SPECIAL PURPOSE COST CENTERS

113.00 | 1300 | INTEREST EXPENSE |
118.00 | SUBTOTALS (SUM OF LINES 1 through 117) |
NONREI MBURSABLE COST CENTERS |
192.00 | 19200 | PHYSI CLANS' | PRI VATE OFFI CES

TOTAL (sum lines 118 through 201)

Cross Foot Adjustments

Negative Cost Centers

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 14-1311

					То	06/30/2023	Date/Time Pre 11/29/2023 10	pared:
				CAPITAL RELATED COSTS			1172772023 10	. 22 aiii
	Cost Center Description	Dire	ctly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription		ed New	BLDG & ITAI	WVBLL LQUIF	Subtotal	BENEFI TS	
		Capi	tal				DEPARTMENT	
			d Costs	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS		)	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P			0	0		0	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL		0	0 419, 738	0 100, 306	0 520, 044	0	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS		0	51, 090	12, 209	63, 299	0	6.00
7.00	00700 OPERATION OF PLANT		0	31, 324	7, 486	38, 810	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE		0	21, 644	5, 172	26, 816	0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY		0	16, 280 2, 217	3, 890 530	20, 170 2, 747	0	9. 00 10. 00
11. 00			0	65, 136	15, 566	80, 702	0	11.00
13.00			0	4, 028	962	4, 990	0	13.00
14.00	1 1		0	0	0	0	0	14.00
15. 00 16. 00	1 1		0	0 24, 927	5, 957	30, 884	0	15. 00 16. 00
17. 00	1 1		0	2, 708	647	3, 355	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENT	ERS		,				
30.00	1 1		0	322, 042	76, 959	399, 001	0	30.00
31. 00 44. 00	1 1		0	22, 558 267, 466	5, 391 63, 917	27, 949 331, 383	0	31. 00 44. 00
44.00	ANCILLARY SERVICE COST CENTERS		<u> </u>	207, 400	03, 717	331, 303	0	44.00
50.00			0	232, 402	55, 538	287, 940	0	50.00
53. 00 54. 00	1		0	77 472	10 514	0 95, 987	0	53. 00 54. 00
60.00	1		0	77, 473 43, 136	18, 514 10, 308	53, 444	0	60.00
65. 00	1		o	31, 730	7, 583	39, 313	0	65. 00
66.00			0	64, 121	15, 323	79, 444	0	66.00
67. 00 68. 00	1		0	14, 249 5, 720	3, 405 1, 367	17, 654 7, 087	0	67. 00 68. 00
69.00	1		0	5, 720	1, 367	7,087	0	69.00
71.00	1 1	ATI ENTS	Ö	33, 321	7, 963	41, 284	Ö	71. 00
72.00	1	6	0	0	0	0	0	72. 00
73.00	1	// CEC	0	55, 829	13, 341	69, 170	0	73.00
76. 00 77. 00	1 1		0	29, 361 0	7, 016 0	36, 377 0	0	76. 00 77. 00
OUTPATIENT SERVICE COST CENTERS								
88.00	1 1		0	528, 705		655, 050	0	88. 00
90. 00 90. 01	1 1		0	195, 104 0	46, 624 0	241, 728 0	0	90. 00 90. 01
90. 01	1 1		o	0	0	ol	0	90.01
90. 03	09003 UROLOGY CLINIC		0	78, 878	18, 850	97, 728	0	90. 03
91.00		- DADT)	0	87, 085	20, 811	107, 896	0	91.00
92. 00 93. 99			0	0	0	0	0	92. 00 93. 99
73. 77	OTHER REIMBURSABLE COST CENTERS	ואור	U	<u> </u>	0	<u> </u>	0	73. 77
	09500 AMBULANCE SERVICES		0	0	0	0		95. 00
	0 10100 HOME HEALTH AGENCY 0 10200 OPIOID TREATMENT PROGRAM		0	32, 492	7, 765	40, 257		101.00
102.00	SPECIAL PURPOSE COST CENTERS		0	0	0	0	U	102. 00
113.00	0 11300 I NTEREST EXPENSE							113. 00
118. 00		ough 117)	0	2, 760, 764	659, 745	3, 420, 509	0	118. 00
102 00	NONREI MBURSABLE COST CENTERS 0 19200 PHYSI CLANS' PRI VATE OFFI CES	I	ام	ما	0	ما	0	192. 00
200.00			٩			ol		200. 00
201.00	Negative Cost Centers			О	0	0	0	201. 00
202.00	0 TOTAL (sum lines 118 through :	201)	0	2, 760, 764	659, 745	3, 420, 509	0	202. 00

Provider CCN: 14-1311

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 07/01/2022 | Part II | Date/Time Prepared: | 11/29/2023 10:22 am | 11/29/2023 am | 11/29/2023 10:22 am | 11/29/2023 am

				'	0 00/30/2023	11/29/2023 10	
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	520, 044					5.00
6.00	00600 MAINTENANCE & REPAIRS	13, 720	77, 019				6.00
7.00	00700 OPERATION OF PLANT	12, 428	1, 054	52, 292			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	8, 037	728	501	36, 082		8.00
9.00	00900 HOUSEKEEPI NG	14, 121	548	377	10, 221	45, 437	9.00
10.00	01000 DI ETARY	5, 646	75	51	416	45	10.00
11. 00	01100 CAFETERI A	7, 349	2, 191	1, 508		1, 333	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 043	135		0	82	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 581	0		0	0	1
15. 00	01500 PHARMACY	29, 528	0		0	Ō	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	8, 536	838		0	510	1
17. 00	01700 SOCIAL SERVICE	2, 443	91	63	0	55	17. 00
.,. 00	INPATIENT ROUTINE SERVICE COST CENTERS	2,	,.				17.00
30.00	03000 ADULTS & PEDI ATRI CS	39, 914	10, 831	7, 456	6, 640	6, 589	30.00
31. 00	03100   NTENSI VE CARE UNI T	731	759	522	0,0.0	462	31.00
44. 00	04400 SKILLED NURSING FACILITY	25, 112	8, 996	6, 192	4, 631	5, 473	1
11.00	ANCILLARY SERVICE COST CENTERS	20, 112	0, 770	0,172	1,001	0, 170	11.00
50.00	05000 OPERATI NG ROOM	33, 153	7, 817	5, 381	5, 001	4, 755	50.00
53. 00	05300 ANESTHESI OLOGY	0	,, 517		0,001	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	31, 175	2, 606	_	2, 010	1, 585	1
60.00	06000 LABORATORY	28, 947	1, 451	999		883	60.00
65.00	06500 RESPIRATORY THERAPY	4, 783	1, 451	735	271	649	65.00
66. 00	06600 PHYSI CAL THERAPY	14, 863	2, 157	1, 485	457	1, 312	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 840	479			292	67.00
68. 00	06800 SPEECH PATHOLOGY	2, 131	192		41	117	68.00
69. 00	06900 ELECTROCARDI OLOGY	116	0	0	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38, 988	1, 121	771	0	682	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1	1, 121	//1	0	002	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	26, 368 946	1, 878		0		1
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	5, 504	988	•	0	1, 142 601	76.00
		5, 504	900	000	0	0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	U	0	0	U	U	77.00
00 00	OUTPATIENT SERVICE COST CENTERS	04 245	17 700	12 241	685	10, 817	00 00
88. 00	08800 RURAL HEALTH CLINIC	84, 265	17, 780			· ·	88.00
90.00	09000 CLINIC	19, 709	6, 562	4, 517	0	3, 992	1
90. 01	09001 WOUND CARE	0	0	0	0	0	90.01
90. 02	09002 PAIN CLINIC	3, 825	0	0	0	0	90.02
90. 03	09003 UROLOGY CLINIC	7, 699	2, 653			1, 614	90.03
91.00	09100 EMERGENCY	27, 393	2, 929	2, 016	5, 110	1, 782	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
05 00	OTHER REIMBURSABLE COST CENTERS						05 00
	09500 AMBULANCE SERVICES	0	0			0	
	10100 HOME HEALTH AGENCY	9, 149	1, 093				101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS			ı			
	11300 I NTEREST EXPENSE						113.00
118.00		520, 043	77, 019	52, 292	36, 082	45, 437	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	1	0	0	0	0	192. 00
200.00	, ,	1					200. 00
201.00		0	0		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	520, 044	77, 019	52, 292	36, 082	45, 437	202. 00

Provider CCN: 14-1311

				10	06/30/2023	11/29/2023 10	pareu: :22 am
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	'			ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10. 00	11. 00	13.00	14. 00	15. 00	
	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FLXT						1. 00
	0200 CAP REL COSTS-MVBLE EQUIP						2. 00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	0500 ADMINI STRATI VE & GENERAL						5. 00
	0600 MAI NTENANCE & REPAI RS						6. 00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPI NG	0.000					9.00
	1000 DI ETARY	8, 980	93. 083				10.00
	1100 CAFETERIA 1300 NURSING ADMINISTRATION	0					11. 00 13. 00
	1400 CENTRAL SERVICES & SUPPLY		2, 420 694		2, 275		14.00
	1500 PHARMACY	0	1, 231		2, 275	30, 774	15.00
	1600 MEDICAL RECORDS & LIBRARY	0	3, 173		4	30, 774	16.00
	1700 SOCIAL SERVICE	0	732		0	0	17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	132	<u> </u>	U]	0	17.00
	3000 ADULTS & PEDIATRICS	2, 257	10, 461	4, 359	22	0	30.00
	3100 I NTENSI VE CARE UNI T	92	14		0	0	31.00
	4400 SKILLED NURSING FACILITY	6, 631	10, 210		32	0	44.00
	NCILLARY SERVICE COST CENTERS	0,00.	.0,2.0	1, 200	021		
	5000 OPERATING ROOM	0	6, 817	2, 841	138	0	50.00
	5300 ANESTHESI OLOGY	O	0		0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	O	6, 906	0	8	0	54.00
60.00 06	6000 LABORATORY	0	11, 468	0	33	0	60.00
65. 00 06	6500 RESPI RATORY THERAPY	0	1, 461	0	5	0	65.00
66.00 0	6600 PHYSI CAL THERAPY	0	4, 118	0	13	0	66.00
67.00 06	6700 OCCUPATI ONAL THERAPY	0	963	0	0	0	67.00
68.00 06	6800 SPEECH PATHOLOGY	0	371	0	0	0	68. 00
69.00 0	6900 ELECTROCARDI OLOGY	0	282	0	0	0	69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1, 098	0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	752	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	30, 774	73. 00
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 385		2	0	76. 00
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	UTPATIENT SERVICE COST CENTERS	ما	10 410		0.2		00.00
	8800 RURAL HEALTH CLINIC	0	13, 413		93	0	88.00
	9000 CLI NI C 9001 WOUND CARE	0	4, 833 0		20	0	90. 00 90. 01
	9002 PAIN CLINIC	0	1, 062	0	0	0	90.01
	9003 UROLOGY CLINIC	0	2, 949	T .	5	0	90.02
	9100 EMERGENCY	0	8, 120		25	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	٩	0, 120	3, 303	23	O	92.00
1	9399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
	THER REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		70.77
	9500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	0100 HOME HEALTH AGENCY	O	0		10	0	101.00
102.00 10	0200 OPIOID TREATMENT PROGRAM	0	0	0	o	0	102.00
SF	PECIAL PURPOSE COST CENTERS						
113. 00 11	1300 I NTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 980	93, 083	15, 763	2, 275	30, 774	118. 00
	ONREI MBURSABLE COST CENTERS						
	9200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0		201.00
202. 00	TOTAL (sum lines 118 through 201)	8, 980	93, 083	15, 763	2, 275	30, 774	202.00

Heal th	Financial Systems	FAIRFIELD MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der CC		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II	epared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16. 00	17. 00	24.00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS	<u> </u>					
1. 00 2. 00 4. 00 5. 00 6. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						1.00 2.00 4.00 5.00 6.00
7. 00 8. 00 9. 00 10. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY						7. 00 8. 00 9. 00 10. 00
11. 00 13. 00 14. 00 15. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						11. 00 13. 00 14. 00 15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	44, 522 0	6, 739				16. 00 17. 00
30.00	03000 ADULTS & PEDIATRICS	1, 104	3, 651	492, 28	5 0	492, 285	30.00
	03100 I NTENSI VE CARE UNI T	53	0,001	30, 58		30, 587	
	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	474	3, 088	406, 47		406, 475	
50.00	05000 OPERATING ROOM	8, 333	0	362, 17	6 0	362, 176	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 742	0	151, 81		151, 813	
60.00	06000 LABORATORY	7, 834	0	105, 55		105, 557	
65. 00	06500 RESPI RATORY THERAPY	1, 287	0	49, 57		49, 571	
66.00	06600 PHYSI CAL THERAPY	1, 110	0	104, 95		104, 959	1
67.00	06700 OCCUPATI ONAL THERAPY	247	0	23, 90		23, 906	
68.00	06800 SPEECH PATHOLOGY	99	0	10, 17		10, 170	
69.00	06900 ELECTROCARDI OLOGY	557	0	95		955	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 704	0	87, 64		87, 648	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 715	0	29, 83 107, 57		29, 835 107, 572	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 369 392	0	107, 57 45, 92		45, 929	
76.00	07700 ALLOGENEIC STEM CELL ACQUISITION	392	0	· ·	0 0	45, 929 0	1
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U		<u> </u>	U	1 / / . 00
88. 00	08800 RURAL HEALTH CLINIC	1, 621	ol	795, 96	5 0	795, 965	88.00
	09000 CLI NI C	254	o			281, 615	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 14-1311

					o 06/30/2023	Date/Time Pre 11/29/2023 10	
		CAPI TAL REI	LATED COSTS			111/29/2023 10	. 22 aiii
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
	South South Person	(SQUARE FEET)		BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1. 00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	163, 138				<u> </u>	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	103, 130	163, 138				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	_			20 000 / 44	4.00
5. 00 6. 00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	24, 803 3, 019	1				5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	1, 851	1, 851		1	1	7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	1, 279 962				587, 440	8. 00 9. 00
	01000 DI ETARY	131	131			1, 032, 070 412, 676	1
11. 00	01100 CAFETERI A	3, 849	3, 849	344, 958	0	537, 122	11. 00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	238				587, 839 115, 589	1
15.00	01500 PHARMACY	0	Ö			l .	1
	01600 MEDICAL RECORDS & LIBRARY	1, 473					1
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	160	160	137, 576	0	178, 586	17.00
30.00	03000 ADULTS & PEDI ATRI CS	19, 030	19, 030	1, 602, 163	0	2, 917, 229	30.00
	03100 INTENSIVE CARE UNIT	1, 333				1	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	15, 805	15, 805	1, 129, 751	0	1, 835, 422	44.00
	05000 OPERATING ROOM	13, 733					
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 4, 578	_			0 2, 278, 532	53. 00 54. 00
60.00	06000 LABORATORY	2, 549				2, 276, 332	60.00
	06500 RESPIRATORY THERAPY	1, 875	1			349, 550	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 789 842	1			1, 086, 320 280, 679	1
68. 00	06800 SPEECH PATHOLOGY	338				155, 733	1
69.00	06900 ELECTROCARDI OLOGY	0	_		1	8, 486	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 969	1, 969 0	1		2, 849, 562 1, 927, 228	1
	07300 DRUGS CHARGED TO PATIENTS	3, 299	1		_	69, 170	73.00
76. 00 77. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	1, 735 0	1				1
77.00	OUTPATIENT SERVICE COST CENTERS				,		77.00
	08800 RURAL HEALTH CLINIC	31, 242					
	09000   CLI NI C   09001   WOUND   CARE	11, 529 0	11, 529 0			1, 440, 521 0	90. 00 90. 01
	09002 PAIN CLINIC	0	Ö	· ·	_	279, 551	
90. 03 91. 00	09003 UROLOGY CLINIC 09100 EMERGENCY	4, 661	4, 661	1, 012, 552			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 146	5, 146	1, 088, 386	0	2,002,143	91.00
	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	<u> </u>	0	0	1
95 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	0	0		0	0	95.00
	10100 HOME HEALTH AGENCY	1, 920	_				
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.00
113. 00	SPECIAL PURPOSE COST CENTERS 11300   INTEREST EXPENSE						1 113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	163, 138	163, 138	21, 771, 519	-5, 648, 194	l	
102 00	NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES	1 0	0		0	66	192. 00
200.00					0		200.00
201.00	3		/50 745			- ,,,	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 760, 764	659, 745	5, 256, 450	)	5, 648, 194	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 922875	4. 044092	0. 241437	1	0. 148603	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)			C		520, 044	204.00
205. 00	1 1 1			0. 000000		0. 013682	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	l	I	l	1	l	l

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS FAIRFIELD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 14-1311

				Ť	06/30/2023	Date/Time Pre	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	. 22 (1111
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE TEET)	(SQUARE TEET)	LAUNDRY)		JERVED)	
C	ENEDAL CEDVICE COCT CENTEDS	6. 00	7. 00	8. 00	9. 00	10. 00	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT						1.00
1	0200 CAP REL COSTS-MVBLE EQUIP						2.00
1	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINISTRATIVE & GENERAL	405.047					5.00
	0600 MAINTENANCE & REPAIRS 0700 OPERATION OF PLANT	135, 316 1, 851	133, 465				6. 00 7. 00
	0800 LAUNDRY & LINEN SERVICE	1, 279	l	1			8.00
	0900 HOUSEKEEPI NG	962	962	1			9. 00
	1000 DI ETARY	131	131			38, 023	1
	1100 CAFETERIA 1300 NURSING ADMINISTRATION	3, 849 238	3, 849 238	1			11. 00 13. 00
	1400 CENTRAL SERVICES & SUPPLY	0	0	1	0	0	14.00
	1500 PHARMACY	0	0	0	0	0	15.00
1	1600 MEDICAL RECORDS & LIBRARY	1, 473	1	i	,		16.00
	1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	160	160	0	160	0	17.00
	3000 ADULTS & PEDIATRICS	19, 030	19, 030	10, 750	19, 030	9, 555	30.00
31.00 03	3100 INTENSIVE CARE UNIT	1, 333	1, 333	0	1, 333	389	31.00
	4400 SKILLED NURSING FACILITY	15, 805	15, 805	7, 498	15, 805	28, 079	44.00
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	13, 733	13, 733	8, 096	13, 733	0	50.00
	5300 ANESTHESI OLOGY	0	1	1			53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	4, 578	4, 578	3, 254	4, 578	0	54.00
	6000 LABORATORY	2, 549	1	1		0	60.00
	6500  RESPI RATORY THERAPY 6600  PHYSI CAL THERAPY	1, 875 3, 789	1	1		0	65. 00 66. 00
1	6700 OCCUPATI ONAL THERAPY	842	842	1		0	67.00
1	6800 SPEECH PATHOLOGY	338	l .	1		0	68.00
	6900 ELECTROCARDI OLOGY	0	0		· ·	0	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 969	1, 969		.,	0	71.00
72. 00 07 73. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	3, 299		_	_	0	72.00 73.00
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 735	l	1	l '		76.00
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	UTPATIENT SERVICE COST CENTERS 8800 RURAL HEALTH CLINIC	31, 242	31, 242	1, 109	31, 242	0	88. 00
	9000 CLINIC	11, 529	l	1	· · · · · · · · · · · · · · · · · · ·		90.00
4	9001 WOUND CARE	0	0		· · · · · · · · · · · · · · · · · · ·	0	90. 01
	9002 PAIN CLINIC	0	0	_	0	0	90.02
	9003 UROLOGY CLINIC 9100 EMERGENCY	4, 661 5, 146	4, 661 5, 146		.,	0	90. 03 91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 140	5, 140	0,2/3	5, 146	0	91.00
	9399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
	THER REIMBURSABLE COST CENTERS			1			05.00
	9500 AMBULANCE SERVICES 0100 HOME HEALTH AGENCY	1, 920	0 1, 920	0			95. 00 101. 00
	0200 OPI OI D TREATMENT PROGRAM	1, 920	1, 920	0			101.00
	PECIAL PURPOSE COST CENTERS				-		
	1300 I NTEREST EXPENSE	105.01/	100 4/5		404 004		113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)  ONREIMBURSABLE COST CENTERS	135, 316	133, 465	58, 415	131, 224	38, 023	]118.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	O	0	192. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 151, 823	1, 059, 096	695, 771	1, 398, 364	485, 568	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 512098	7. 935384	11. 910828	10. 656313	12. 770376	203. 00
204. 00	Cost to be allocated (per Wkst. B,	77, 019	l	1			204. 00
205 20	Part II)	0.5/0470	0.004655	0 (47/0)	0.04/0==	0.00/470	005 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 569179	0. 391803	0. 617684	0. 346255	0. 236173	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
00=	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
I	parts iii anu iv)	I	I	I		I	I

COST A	LLOCATION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
					rom 07/01/2022 o 06/30/2023		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	11/29/2023 10 MEDI CAL	): 22 am
		(FTES SERVED)	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
			N N	SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT NURS. HRS.)	(COSTED REQUIS.)		(TIME SPENT)	
		11. 00	13. 00	14.00	15. 00	16. 00	
<u> </u>	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	OO100   CAP REL COSTS-BLDG & FIXT   OO200   CAP REL COSTS-MVBLE EQUIP						1.00
4. 00	100400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE						7.00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	27, 078					11.00
13. 00 14. 00	01300   NURSI NG ADMI NI STRATI ON   01400   CENTRAL SERVI CES & SUPPLY	704 202	•	5, 827, 341			13.00
15. 00	01500 PHARMACY	358		38, 503	100		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	923		10, 126	I I	142, 043, 175	
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	213	0	283	0	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	3, 043	63, 299	55, 518	ol	3, 525, 567	30.00
31. 00	03100 INTENSIVE CARE UNIT	4	74	838	I .	170, 700	1
44. 00	04400 SKILLED NURSING FACILITY	2, 970	61, 770	81, 570	0	1, 515, 819	44.00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	1, 983	41, 256	354, 951	ol	26, 624, 053	50.00
53. 00	05300 ANESTHESI OLOGY	1, 763		354, 751		20, 024, 033	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 009		20, 107	I I	30, 928, 751	54.00
60.00	06000 LABORATORY	3, 336		85, 681	0	25, 027, 541	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	425 1, 198		13, 022 33, 199	I I	4, 112, 750 3, 546, 652	
67. 00	06700 OCCUPATI ONAL THERAPY	280		00, 177	I I	788, 063	
68. 00	06800 SPEECH PATHOLOGY	108		C		316, 432	
69. 00 71. 00	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	82 0		2, 808, 278	0	1, 778, 303 11, 833, 721	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		1	1, 927, 228	I I	8, 672, 524	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		l I	7, 568, 785	73.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	403			I I	1, 251, 705	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	C	ıl U	0	77.00
88. 00	08800 RURAL HEALTH CLINIC	3, 902	0	239, 328	0	5, 178, 758	88. 00
90.00	09000 CLINIC	1, 406		50, 355	I I	811, 418	
90. 01 90. 02	O9001   WOUND CARE   O9002   PAIN CLINIC	309	0	625 625	- 1	0 131, 922	
90. 03	09003 UROLOGY CLINIC	858	0	13, 517	I I	739, 858	
	09100 EMERGENCY	2, 362	49, 136	63, 363	o	7, 519, 853	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	l c	o	0	92. 00 93. 99
73. 77	OTHER REIMBURSABLE COST CENTERS		0		۷	0	73.77
	09500 AMBULANCE SERVICES	0		C			95. 00
	10100 HOME HEALTH AGENCY 10200 OPLOID TREATMENT PROGRAM	0		25, 612 C	l i		101. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	0	0		ıj Oj	0	1102.00
	11300 INTEREST EXPENSE						113.00
118. 00		27, 078	228, 921	5, 827, 275	100	142, 043, 175	118.00
192.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	66	l ol	0	192. 00
200.00	Cross Foot Adjustments						200.00
201.00		701 040	700 207	120 147	2 400 204	701 250	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	721, 262	700, 397	138, 147	2, 489, 284	781, 359	202.00
203.00		26. 636458			1 '	0. 005501	
204.00	***	93, 083	15, 763	2, 275	30, 774	44, 522	204.00
205.00	Part II)   Unit cost multiplier (Wkst. B, Part	3. 437588	0. 068858	0. 000390	307. 740000	0. 000313	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)		l				

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1311 Peri od: Worksheet B-1

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/29/2023 10:22 am Cost Center Description SOCI AL SERVI CE (TIME SPENT) 17 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 2,047 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 1, 109 03100 INTENSIVE CARE UNIT 31.00 0 31 00 04400 SKILLED NURSING FACILITY 938 44.00 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0000000 60.00 06000 LABORATORY 60.00 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 73 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88 00 08800 RURAL HEALTH CLINIC 0 90.00 09000 CLI NI C 90.00 0 09001 WOUND CARE 90.01 90.01 0 90 02 09002 PAIN CLINIC 90.02 09003 UROLOGY CLINIC 90.03 90.03 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09399 PARTI AL HOSPI TALI ŽATI ON PROGRAM 0 93.99 93 99 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 95.00 101.00 10100 HOME HEALTH AGENCY 101.00 0

SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 215, 142 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 105. 101124 203.00 204.00 Cost to be allocated (per Wkst. B, 6.739 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 3. 292135 205.00 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

0

2,047

102.00

113.00

118.00

102.00 10200 OPI OID TREATMENT PROGRAM

113. 00 11300 I NTEREST EXPENSE

118.00

SPECIAL PURPOSE COST CENTERS

Health Financial Systems	FAIRFIELD MEMOI	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/29/2023 10	
		Title	XVIII	Hospi tal	Cost	
		·		Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit	Total Costs	RCE Di sal Lowance	Total Costs	

				'	0 00/30/2023	11/29/2023 10	: 22 am
			Title	XVIII	Hospi tal	Cost	
			<u>'</u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst.	Áďj.		Di sal I owance		
		B, Part I,	,				
		col. 26)					
		1.00	2. 00	3.00	4. 00	5. 00	
Ī	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 528, 575		4, 528, 575	o	4, 528, 575	30.00
	03100 INTENSIVE CARE UNIT	103, 782		103, 782		103, 782	1
	04400 SKILLED NURSING FACILITY	3, 361, 390		3, 361, 390		3, 361, 390	
	NCILLARY SERVICE COST CENTERS				-	27 22 17 2 12	
	05000 OPERATING ROOM	3, 585, 722		3, 585, 722	0	3, 585, 722	50.00
	05300 ANESTHESI OLOGY	0		0,000,1	ol ol	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 004, 075		3, 004, 075		3, 004, 075	1
	06000 LABORATORY	2, 737, 327		2, 737, 327		2, 737, 327	60.00
	06500 RESPIRATORY THERAPY	491, 784	0	491, 784	l l	491, 784	1
	06600 PHYSI CAL THERAPY	1, 411, 467	0	1, 411, 467	1	1, 411, 467	
	06700 OCCUPATI ONAL THERAPY	358, 957	0	358, 957		358, 957	67.00
	06800 SPEECH PATHOLOGY	193, 440	0	193, 440		193, 440	•
	06900 ELECTROCARDI OLOGY	21, 713	0	21, 713		21, 713	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 458, 051		3, 458, 051		3, 458, 051	
	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 307, 017		2, 307, 017	1	2, 307, 017	
	07300 DRUGS CHARGED TO PATIENTS	2, 699, 784		2, 699, 784		2, 699, 784	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	526, 842		526, 842		526, 842	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0 520, 642		520, 642		0 520, 642	ł
	DUTPATIENT SERVICE COST CENTERS	ı v			ı U	U	77.00
	08800 RURAL HEALTH CLINIC	8, 071, 159		8, 071, 159	ol	8, 071, 159	88. 00
	09000 CLINIC	2, 010, 176		2, 010, 176		2, 010, 176	
							1
	09001 WOUND CARE	0		220.045	-	0	90. 01
	09002 PAIN CLINIC	330, 065		330, 065		330, 065	
	09003 UROLOGY CLINIC	799, 940		799, 940		799, 940	•
	09100 EMERGENCY	2, 793, 798		2, 793, 798		2, 793, 798	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 394, 086		1, 394, 086		1, 394, 086	
	9399 PARTI AL HOSPI TALI ZATI ON PROGRAM	[0]			0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0		C			95.00
	10100 HOME HEALTH AGENCY	861, 693		861, 693		861, 693	
	10200 OPIOID TREATMENT PROGRAM	0				0	102. 00
	SPECIAL PURPOSE COST CENTERS	1			1		
	11300 INTEREST EXPENSE	45 050 5 1	_	45 050 5 :-	_	45 050 5:5	113.00
200.00	Subtotal (see instructions)	45, 050, 843	0			45, 050, 843	
201.00	Less Observation Beds	1, 394, 086		1, 394, 086	1	1, 394, 086	
202. 00	Total (see instructions)	43, 656, 757	0	43, 656, 757	0	43, 656, 757	202.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1311	Period: Worksheet C From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

				1	o 06/30/2023	Date/Time Pre 11/29/2023 10	
			Title	XVIII	Hospi tal	Cost	. ZZ GIII
			Charges				
C	cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
				<u> </u>		Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
I NPATI E	ENT ROUTINE SERVICE COST CENTERS	•					
30. 00 03000 A	DULTS & PEDIATRICS	2, 026, 496		2, 026, 496			30.00
31.00 03100 I	NTENSIVE CARE UNIT	170, 700		170, 700			31.00
44. 00 04400 S	KILLED NURSING FACILITY	1, 515, 819		1, 515, 819			44.00
ANCI LLA	ARY SERVICE COST CENTERS						
50.00 05000 0	PERATING ROOM	2, 120, 966	24, 503, 087	26, 624, 053	0. 134680	0.000000	50.00
53. 00 05300 A	NESTHESI OLOGY	0	0	(	0. 000000	0.000000	53.00
54.00 05400 R	ADI OLOGY-DI AGNOSTI C	1, 120, 554	29, 808, 197	30, 928, 751	0. 097129	0.000000	54.00
60.00 06000 L	ABORATORY	1, 782, 576	23, 244, 965	25, 027, 541	0. 109373	0.000000	60.00
65. 00 06500 R	ESPI RATORY THERAPY	1, 470, 773	2, 641, 977	4, 112, 750	0. 119575	0.000000	65.00
66. 00 06600 P	PHYSI CAL THERAPY	475, 078	3, 071, 574	3, 546, 652	0. 397972	0.000000	66.00
67.00 06700 0	CCUPATI ONAL THERAPY	495, 854	292, 209			0.000000	67.00
68. 00 06800 S	PEECH PATHOLOGY	93, 504	222, 928	316, 432	0. 611316	0.000000	68.00
	LECTROCARDI OLOGY	170, 146	1, 608, 157	1, 778, 303	0. 012210	0.000000	69.00
	IEDICAL SUPPLIES CHARGED TO PATIENTS	1, 458, 643	10, 375, 078	11, 833, 721	0. 292220	0.000000	71.00
	MPL. DEV. CHARGED TO PATIENTS	1, 019, 649	7, 652, 875			0.000000	
	RUGS CHARGED TO PATIENTS	1, 743, 878	5, 824, 907			0. 000000	73.00
	SYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 251, 705			0. 000000	
	LLOGENEIC STEM CELL ACQUISITION	O	0			0. 000000	
	ENT SERVICE COST CENTERS	-1					
	URAL HEALTH CLINIC	0	5, 178, 758	5, 178, 758	3		88. 00
90. 00 09000 C	LINIC	760	810, 658	811, 418	2. 477362	0.000000	90.00
90. 01 09001 W	OUND CARE	o	0	1 (	0. 000000	0.000000	90. 01
90. 02 09002 P	PAIN CLINIC	O	131, 922	131, 922		0. 000000	
90. 03 09003 U	IROLOGY CLINIC	O	739, 858			0.000000	90. 03
91.00 09100 E	MERGENCY	144, 656	7, 375, 197	7, 519, 853	0. 371523	0.000000	91.00
	BSERVATION BEDS (NON-DISTINCT PART)	24, 520	1, 474, 551			0. 000000	
	ARTIAL HOSPITALIZATION PROGRAM	0	0			0. 000000	
	REIMBURSABLE COST CENTERS	-1					
	MBULANCE SERVICES	0	0	(	0.000000	0.000000	95.00
101. 00 10100 H	IOME HEALTH AGENCY	0	540, 033	540, 033	3		101.00
102. 00 10200 0	PIOID TREATMENT PROGRAM	0	0				102.00
	PURPOSE COST CENTERS			•	'		
113. 00 11300 I	NTEREST EXPENSE						113.00
200.00 S	Subtotal (see instructions)	15, 834, 572	126, 748, 636	142, 583, 208	3		200.00
	ess Observation Beds						201.00
202. 00 T	otal (see instructions)	15, 834, 572	126, 748, 636	142, 583, 208	3		202.00
' '	•			•		'	•

Health Financial Systems	FAIRFIELD MEMORIA	AL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-1311	From 07/01/2022	Worksheet C Part I Date/Time Pre 11/29/2023 10	pared: : 22 am
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				

INPATIENT ROUTINE SERVICE COST CENTERS   30.00   30000 ADULTS & PEDIATRIC S   31.00   31.00   31.00   30000   INTENSI VE CARE UNIT   31.00   44.00   644.0				litle XVIII	Hospi tal	Cost
INPATI ENT. ROUTINE_SERVICE_COST_CENTERS   30. 00   33.00   ADULTS & PEDI ATRICS   31. 00   33.00   ADULTS & PEDI ATRICS   31. 00   33.10   ADULTS & PEDI ATRICS   31. 00   33.10   ADULTS & PEDI ATRICS   44. 00   44. 0		Cost Center Description	PPS Inpatient			
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   310.00   300.00   300.00   AULITS & PEDI ATRICES   31.00			Ratio			
30. 00   03000  ADULTS & PEDIATRICS   30. 00   31. 00			11. 00			
31.00   03100   INTERSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS				
44.00	30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS   So. 00	31.00	03100 INTENSIVE CARE UNIT				31.00
SO. 00   05000   05000   056	44.00	04400 SKILLED NURSING FACILITY				44.00
53.00   05300   ANESTHESI OLOGY   0.000000   0.5400   RADI OLOGY-DI AGNOSTI C   0.097129   0.00000   0.00000   ABORATORY   0.109373   0.00000   0.0000   LABORATORY   0.109373   0.00000   0.00000   LABORATORY   0.119575   0.5000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		ANCILLARY SERVICE COST CENTERS				
54.00   05400   RADI OLGCY_DI AGNOSTI C   0.097129   0.109373   0.0000   0.0000   LABORATORY   0.109373   0.0000   0.0000   CABORATORY   0.119575   0.5000   0.00000   0.00000   0.0000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	50.00	05000 OPERATING ROOM	0. 134680			50.00
60.00   06000   LABORATORY   0.109373   65.00   06500   RESPI RATORY THERAPY   0.119575   65.00   06600   PHYSI CAL THERAPY   0.397972   66.00   06600   PHYSI CAL THERAPY   0.397972   66.00   06600   PHYSI CAL THERAPY   0.455493   67.00   06700   0CCUPATI ONAL THERAPY   0.455493   67.00   06800   SPEECH PATHOLOGY   0.611316   68.00   06800   SPEECH PATHOLOGY   0.012210   69.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.292220   71.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.292220   71.00   07300   DRUGS CHARGED TO PATI ENTS   0.266014   72.00   07300   DRUGS CHARGED TO PATI ENTS   0.356700   73.00   76.00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0.420899   76.00   00700   CLECK COST CENTERS   88.00   08800   RURAL HEALTH CLI NI C   0.000000   000000   000000   000000   000000	53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
65. 00   06500   RESPIRATORY THERAPY   0. 119575   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 397972   66. 00   66. 00   0600   PHYSI CAL THERAPY   0. 455493   67. 00   06700   OCCUPATI ONAL THERAPY   0. 455493   67. 00   06800   SPEECH PATHOLOGY   0. 611316   68. 00   06900   ELECTROCARDI OLOGY   0. 012210   071.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 292220   71. 00   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 292220   77. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 356700   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 356700   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 356700   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 00000000	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 097129			54.00
66. 00   06600   PHYSI CAL THERAPY   0. 397972   66. 00   06700   0CCUPATI ONAL THERAPY   0. 455493   67. 00   06700   0CCUPATI ONAL THERAPY   0. 455493   67. 00   06900   0CCUPATI ONAL THERAPY   0. 651493   68. 00   06800   SPECH PATHOLOGY   0. 611316   68. 00   06900   0. 06900   0. 06900   0. 06100   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	60.00	06000 LABORATORY	0. 109373			60.00
67. 00   06700   06700   0CCUPATI ONAL THERAPY   0. 455493   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 611316   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 0112210   69. 00   71. 00   71. 00   71. 00   71. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 292220   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 266014   72. 00   73. 00   07300   DRIGS CHARGED TO PATI ENTS   0. 356700   73. 00   76. 00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0. 420899   76. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   0000   CLI IN C   0. 000000   0000   CLI IN C   0. 000000   0000   CLI IN C   0. 000000   0. 000000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 00000000	65.00	06500 RESPIRATORY THERAPY	0. 119575			65.00
68. 00   06800   SPEECH PATHOLOGY   0. 611316   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 012210   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 292220   71. 00   72. 00   77. 00	66.00	06600 PHYSI CAL THERAPY	0. 397972			66.00
69. 00   06900   ELECTROCARDI OLOGY   0. 012210   69. 00   71. 00   771. 00   771. 00   771. 00   771. 00   771. 00   771. 00   771. 00   772. 00   772. 00   772. 01   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 292220   771. 00   772. 00   772. 01   MPL. DEV. CHARGED TO PATIENTS   0. 356700   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00	67.00	06700 OCCUPATI ONAL THERAPY	0. 455493			67.00
69. 00   06900   ELECTROCARDI OLOGY   0. 012210   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 292220   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 266014   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 356700   73. 00   76. 00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0. 420899   76. 00   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   00TPATIENT SERVI CE COST CENTERS    88. 00   08800   RURAL HEALTH CLINI C   2. 477362   90. 01   90. 01   09001   WOUND CARE   0. 000000   90. 01   90. 02   09002   PAIN CLINI C   2. 501971   90. 02   90. 03   09003   UROLOGY CLINI C   1. 081207   90. 03   91. 00   09100   EMERGENCY   91. 00   92. 00   09200   085ERVATI ON BEDS (NON-DI STI NCT PART)   0. 929967   92. 00   93. 99   07100   EMERGENCY   0. 371523   99. 03399   PARTI AL HOSPI TALIZATI ON PROGRAM   0. 000000   93. 99   0THER REI MBURSABLE COST CENTERS   95. 00   95. 00   09500   AMBULANCE SERVI CES   0. 000000   95. 00   101. 00   10100   HOME HEALTH AGENCY   101. 00   102. 00   10200   OPI OI D TREATMENT PROGRAM   0. 000000   95. 00   102. 00   10200   OPI OI D TREATMENT PROGRAM   102. 00   SPECIAL PURPOSE COST CENTERS   113. 00	68.00	06800 SPEECH PATHOLOGY	0. 611316			68.00
71. 00		06900 ELECTROCARDI OLOGY	0. 012210			69.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 266014   72. 00   73	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 292220			71.00
73. 00						
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 420899 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 77. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 80. 000000 CLI NI C 90. 00 09000 OPO CLI NI C 90. 00 09000 OPO OPO CLI NI C 90. 00 09000 OPO OPO OPO OPO OPO OPO OPO OPO OPO	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 356700			73.00
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SITI ON   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000						
88. 00 90. 00 90. 00 90. 00 90. 00 90. 01 90. 01 90. 01 90. 02 90. 02 90. 02 90. 03 90. 03 90. 03 90. 03 90. 00 90						
90. 00   09000   CLINI C   2. 477362   90. 00   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 02   90. 01   90. 02   90. 02   90. 02   90. 02   90. 03		OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
90. 01   09001   WOUND CARE   0. 000000   90. 01   90. 02   90. 02   90. 02   90. 02   90. 03   09003   UROLOGY CLINIC   1. 081207   90. 03   91. 00   09100   EMERGENCY   0. 371523   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0. 929967   92. 00   93. 99   PARTI AL HOSPI TALI ZATI ON PROGRAM   0. 000000   93. 99   OTHER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   0. 000000   09500   AMBULANCE SERVI CES   0. 000000   101. 00   10100   HOME HEALTH AGENCY   101. 00   10200   0PI 0I D TREATMENT PROGRAM   102. 00   SPECI AL PURPOSE COST CENTERS   113. 00   1300   INTEREST EXPENSE   113. 00   1300   INTEREST EXPENSE   113. 00   11300   11300   11300   1000   1	88.00	08800 RURAL HEALTH CLINIC				88. 00
90. 02   09002   PAI N CLINI C   2. 501971   90. 02   90. 03   09003   UROLOGY CLINI C   1. 081207   90. 03   91. 00   09100   EMERGENCY   0. 371523   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 929967   92. 00   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0. 000000   93. 99   00000   00000   000000   000000   000000	90.00	09000 CLI NI C	2. 477362			90.00
90. 03	90. 01	09001 WOUND CARE	0. 000000			90. 01
91. 00	90.02	09002 PAIN CLINIC	2. 501971			90. 02
92. 00   09200   08SERVATI ON BEDS (NON-DI STI NCT PART)   0. 929967   0. 000000   93. 99   07HER REI MBURSABLE COST CENTERS   09500   AMBULANCE SERVI CES   0. 000000   010100   HOME HEALTH AGENCY   010200   0PI 0I D TREATMENT PROGRAM   102. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST E	90. 03	09003 UROLOGY CLINIC	1. 081207			90. 03
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0. 000000   93. 99	91.00	09100 EMERGENCY	0. 371523			91.00
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0. 000000   93. 99	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 929967			92.00
95. 00			0. 000000			93. 99
101.00		OTHER REIMBURSABLE COST CENTERS				
102.00   10200   OPI 0I D TREATMENT PROGRAM   102.00   SPECI AL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00	95.00	09500 AMBULANCE SERVICES	0. 000000			95.00
SPECIAL PURPOSE COST CENTERS  113.00   11300   INTEREST EXPENSE   113.00	101.00	10100 HOME HEALTH AGENCY				101.00
113. 00 11300   INTEREST EXPENSE 113. 00	102.00	10200 OPIOID TREATMENT PROGRAM				102.00
		SPECIAL PURPOSE COST CENTERS	· '			
200 00   Subtotal (see instructions)	113.00	11300 I NTEREST EXPENSE				113.00
200.00	200.00	Subtotal (see instructions)				200. 00
201.00 Less Observation Beds 201.00	201.00	Less Observation Beds				201. 00
202.00 Total (see instructions) 202.00	202.00	Total (see instructions)				202.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared:

					To 06/30/2023	Date/Time Pre	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,	,				
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 528, 575		4, 528, 57	5 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	103, 782		103, 78	2 0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	3, 361, 390		3, 361, 39	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000  OPERATI NG ROOM	3, 585, 722		3, 585, 72	2 0	0	
53.00	05300 ANESTHESI OLOGY	0			0	0	
54.00	05400  RADI OLOGY-DI AGNOSTI C	3, 004, 075		3, 004, 07		0	
	06000 LABORATORY	2, 737, 327		2, 737, 32	7 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	491, 784	0			0	65.00
	06600 PHYSI CAL THERAPY	1, 411, 467	0	1, 411, 46		0	
67.00	06700 OCCUPATI ONAL THERAPY	358, 957	0	358, 95		0	67.00
68. 00	06800 SPEECH PATHOLOGY	193, 440	0	193, 44		0	68. 00
	06900 ELECTROCARDI OLOGY	21, 713		21, 71		0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 458, 051		3, 458, 05		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 307, 017		2, 307, 01		0	1
	07300 DRUGS CHARGED TO PATIENTS	2, 699, 784		2, 699, 78		0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	526, 842		526, 84		0	76. 00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	8, 071, 159		8, 071, 15		0	
	09000 CLINIC	2, 010, 176		2, 010, 17		0	
	09001 WOUND CARE	0			0	0	
	09002 PAIN CLINIC	330, 065		330, 06		0	
	09003 UROLOGY CLINIC	799, 940		799, 94		0	1
91.00	09100 EMERGENCY	2, 793, 798		2, 793, 79		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 394, 086		1, 394, 08		0	
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0			0 0	0	93. 99
05 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES			1	0 0	0	95. 00
	10100 HOME HEALTH AGENCY	0 861, 693		861, 69			101.00
	10200 OPIOLD TREATMENT PROGRAM	801, 093			0		102.00
102.00	SPECIAL PURPOSE COST CENTERS	0			U	U	1102.00
113 00	11300 I NTEREST EXPENSE						113.00
200.00		45, 050, 843	0	45, 050, 84	3 0	^	200.00
201.00		1, 394, 086		1, 394, 08			201.00
202.00		43, 656, 757					202.00
202.00	Trotal (See That delibins)	1 45,050,757	ı	1 75,050,75	, i	U	1202.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared:

Title XIX						To 06/30/2023		
Cost Center Description				Ti +I	o VIV	Hospi tal		. ZZ alli
Inpatient   Outpatient   Outpatient   Total (col. 6   Cost or 0ther   Ratio   Inpatient   Inpati					C XIX	nospi tai	0031	
NATIENT ROUTINE SERVICE COST CENTERS   6.00   7.00   8.00   9.00   10.00		Cost Cantar Description	Innationt		Total (col 4	Cost or Other	TEEDV	
INPATIENT ROUTINE SERVICE COST CENTERS		cost center bescription	Tripati ent	outpatrent				
INPATI ENT ROUTI NE SERVI CE COST CENTERS					1 001. 7)	Ratio	•	
INPATI ENT ROUTINE SERVICE COST CENTERS   0			6.00	7 00	8 00	9 00		
30. 00   03000   ADULTS & PEDIATRICS   0   0   0   31. 00		INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
31.00   03100   INTENSIVE CARE UNIT   0   0   0   44.00   04.00   5KILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0	30 00		0			n l		30.00
44. 00   04400   SKI LLED NURSI NG FACILITY			1			-		
ANCILLARY SERVICE COST CENTERS			1 1		•	-		
50.00			9		1			
53.00   05300   AMESTHESI OLOGY   0   0   0   0   0   0   0   0   0	50.00		0	0		0.000000	0.000000	50.00
54. 00			0	0				
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			0	0				
65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   0   0   0   0   0			0	0				
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0.000000 0.000000 66.00 67.00 68.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 0.000000 67.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 0.000000 69.00 0.000000 69.00 0.000000 0.000000 0.000000 0.000000 0.000000				0				
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0.000000   0.000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0.000000   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0.000000   0.000000   0.000000   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0.000000   0.000000   71. 00   72. 00   07200   IMPL   DEV. CHARGED TO PATI ENTS   0   0   0.000000   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0.000000   0.000000   72. 00   74. 00   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0.000000   0.000000   0.000000   77. 00   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0.000000   0.000000   77. 00    00TPATI ENT SERVI CE COST CENTERS  88. 00   08800   RURAL HEALTH CLI NI C   0   0   0.000000   0.000000   90. 00   90. 01   09900   CLI NI C   0   0   0.000000   0.000000   90. 00   90. 01   09901   WOUND CARE   0   0   0   0.000000   0.000000   90. 01   90. 02   09002   PAI N CLI NI C   0   0   0.000000   0.000000   90. 02   90. 03   09003   UROLOGY CLI NI C   0   0   0.000000   0.000000   90. 03   91. 00   09100   EMERGENCY   0   0   0.000000   0.000000   91. 00   93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0.000000   0.000000   95. 00   101. 00   10100   HOME HEALTH ACENCY   0   0   0   0.000000   0.000000   95. 00   102. 00   OPECI AL PURPOSE COST CENTERS				-				
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 0.000000 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0.000000 0.000000 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000000 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0.000000 0.000000 72. 00 74. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0.000000 0.000000 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0.000000 0.000000 76. 00  77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0.000000 0.000000 77. 00  DUTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0.000000 0.000000 90. 00 90. 01 09000 CLI NI C 0 0 0 0.000000 0.000000 90. 00 90. 01 09000 CLI NI C 0 0 0 0.000000 0.000000 90. 00 90. 01 09000 CLI NI C 0 0 0 0.000000 0.000000 90. 00 90. 02 09002 PAI N CLI NI C 0 0 0 0.000000 0.000000 90. 02 90. 03 09003 UROLOGY CLI NI C 0 0 0 0.000000 0.000000 90. 02 91. 00 09100 EMERGENCY 0 0 0 0.000000 0.000000 90. 03 91. 00 09100 EMERGENCY 0 0 0 0.000000 0.000000 92. 00 93. 99 DARTI AL HOSPITALI ZATI ON PROGRAM 0 0 0 0.000000 0.000000 95. 00  95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0.000000 0.000000 95. 00  101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0.000000 0.000000 95. 00  SPECI AL PURPOSE COST CENTERS				-				
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0.000000 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0.000000 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0.000000 0.000000 72. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0.000000 0.000000 73. 00 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0.000000 0.000000 0.000000 77. 00 00TPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0.000000 0.000000 90. 00 90. 01 09001 WOUND CARE 0 0 0 0 0 0.000000 0.000000 90. 01 90. 02 09002 PAI N CLI NI C 0 0 0 0 0.000000 0.000000 90. 01 90. 03 09003 UROLOGY CLI NI C 0 0 0 0.000000 0.000000 90. 02 91. 00 09100 EMERGENCY 0 0 0 0 0.000000 0.000000 91. 00 92. 00 09309 PARTI AL HOSPI TALI ZATI ON PROGRAM 0 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 0 0 0 0 0.000000 0.000000 92. 00 97. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0.000000 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0.000000 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0.000000 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0.000000 0.000000 95. 00 102. 00 0FECI AL PURPOSE COST CENTERS		1		0				
71. 00				-				
72. 00				-				
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0.000000 73. 00 76. 00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0.000000 76. 00 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0.000000 0.000000 77. 00  DUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 0.000000 90. 00  90. 01 09001 WOUND CARE 0 0 0 0.000000 0.000000 90. 01  90. 02 09002 PAIN CLINIC 0 0 0 0.000000 0.000000 90. 01  90. 03 09003 UROLOGY CLINIC 0 0 0 0.000000 0.000000 90. 02  90. 03 09003 UROLOGY CLINIC 0 0 0 0.000000 0.000000 90. 02  90. 09 09100 EMERGENCY 0 0 0 0.000000 0.000000 91. 00  92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0.000000 0.000000 92. 00  93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 0.000000 0.000000 93. 99  OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0.000000 0.000000 95. 00  SPECIAL PURPOSE COST CENTERS				0				
76. 00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0.000000 76. 00 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0.000000 77. 00 0.000000 77. 00 0.000000 0.000000 77. 00 0.000000 0.000000 77. 00 0.000000 0.000000 0.000000 77. 00 0.000000 0.000000 0.000000 0.000000				0				
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0   0   0   0   0   0				0				
SERVICE COST CENTERS   SURVICE COST CENTERS			1		1			
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0.000000 0.000000 90. 00 90. 00 09000 CLINIC 0 0 0 0 0.000000 0.000000 90. 00 90. 01 09001 WOUND CARE 0 0 0 0 0.000000 0.000000 90. 01 90. 02 09002 PAIN CLINIC 0 0 0 0 0 0.000000 0.000000 90. 02 90. 03 09003 UROLOGY CLINIC 0 0 0 0 0.000000 0.000000 90. 03 91. 00 09100 EMERGENCY 0 0 0 0 0.000000 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0.000000 0.000000 92. 00 93. 99 071HER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0.000000 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0.000000 0.000000 95. 00 102. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0.000000 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0.000000 0.000000 95. 00 102. 00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 0 0 0.000000 0.000000 1010. 00 SPECIAL PURPOSE COST CENTERS	,,,,,,,		91		1	0.00000	0.00000	,,,,,,,
90. 00   09000   CLINIC   0   0   0   0   0   0   0   0   0	88. 00		0	0		0.000000	0.000000	88.00
90. 01   09001   WOUND CARE   0   0   0   0.000000   0.000000   90. 01   90. 02   09002   PAI N CLINIC   0   0   0   0.000000   0.000000   90. 02   90. 03   09003   UROLOGY CLINIC   0   0   0   0.000000   0.000000   90. 03   91. 00   09100   EMERGENCY   0   0   0   0.000000   0.000000   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0.000000   0.000000   92. 00   93. 99   OTHER REIMBURSABLE COST CENTERS   0   0   0.000000   0.000000   93. 99   95. 00   09500   AMBULANCE SERVICES   0   0   0.000000   0.000000   95. 00   101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   102. 00   SPECIAL   PURPOSE COST CENTERS			1		1			
90. 02   09002   PAI N CLINI C   0   0   0   0.000000   0.000000   90.02   90. 03   09003   UROLOGY CLINI C   0   0   0   0.000000   0.000000   90.03   91. 00   09100   EMERGENCY   0   0   0   0.000000   0.000000   91.00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0.000000   0.000000   92.00   93. 99   OTHER REIMBURSABLE COST CENTERS   0   0   0.000000   0.000000   93. 99   95. 00   09500   AMBULANCE SERVI CES   0   0   0   0.000000   0.000000   95. 00   101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   102. 00   SPECIAL   PURPOSE COST CENTERS				-	1			
90. 03   09003   UROLOGY CLINIC   0   0   0   0.000000   0.000000   90.03   91.00   91.00   09100   EMERGENCY   0   0   0   0.000000   0.000000   91.00   92.00   93.99   PARTI AL HOSPITALI ZATI ON PROGRAM   0   0   0.000000   0.000000   93.99   PARTI AL HOSPITALI ZATI ON PROGRAM   0   0   0.000000   0.000000   93.99   95.00   O9500   AMBULANCE SERVI CES   0   0   0   0.000000   0.000000   95.00   09500   AMBULANCE SERVI CES   0   0   0   0.000000   0.000000   95.00   0.0000000   0.000000				0	1			
91. 00   09100   EMERGENCY   0   0   0   0.000000   0.000000   91. 00   92. 00   09200   08SERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0.000000   0.000000   92. 00   93. 99   09399   PARTI AL HOSPITALI ZATI ON PROGRAM   0   0   0   0.000000   0.000000   93. 99   07HER REIMBURSABLE COST CENTERS   0   0   0   0.000000   0.000000   95. 00   0.0000000   0.0000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000				0				
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0.000000   0.000000   92. 00   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0.000000   0.000000   93. 99   0THER REI MBURSABLE COST CENTERS   0   0   0   0.000000   0.000000   95. 00   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0.000000   101. 00   10200   0PI OID TREATMENT PROGRAM   0   0   0   0.000000   102. 00   102.00   102.00   SPECI AL PURPOSE COST CENTERS				0				
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   0   0   0   0				-				
OTHER REIMBURSABLE COST CENTERS  95. 00			1		1			
95. 00   09500   AMBULANCE SERVI CES   0 0 0 0.000000   0.000000   95. 00   101. 00   10100   HOME   HEALTH   AGENCY   0 0 0   0 0   102. 00   102. 00   SPECI AL   PURPOSE   COST   CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	70. 77		9			0.00000	0.00000	70.77
101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 102.00 OPI 0I D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS	95. 00		0	0		0. 000000	0.000000	95.00
102.00 0 10200 OPLOID TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS			1		l .		0.00000	
SPECIAL PURPOSE COST CENTERS			1 1		1	·		
			-1	-		-		
TIO, COLLIDOULT WIENED I EALENDE I IIIO, COL	113.00	11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions) 0 0 0 200.00			l	0				
201.00 Less Observation Beds 201.00			1	_				
202.00 Total (see instructions) 0 0 0 202.00		l l	o	0		o		

<u> </u>	FAIRFIELD MEMORI	AL HOSPITAL	In Lieu	of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/29/2023 10	epared: ): 22 am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT					30. 00 31. 00 44. 00
44.00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS					44.00
50. 00 05000 OPERATING ROOM	0. 000000				50.00
53. 00   05300  OFERATING ROOM 53. 00   05300  ANESTHESI OLOGY	0.000000				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0.000000				54.00
60. 00   06000   LABORATORY	0. 000000				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77.00
OUTPATIENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
90. 00   09000   CLI NI C	0. 000000				90.00
90. 01 09001 WOUND CARE	0. 000000				90. 01
90. 02   09002   PAIN CLINIC	0. 000000				90.02
90. 03   09003   UROLOGY   CLINIC	0. 000000				90.03
91. 00   09100   EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000				93. 99

0.000000

95.00

101.00

102.00

113. 00 200. 00 201. 00 202. 00

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

102. 00 10200 OPI OI D TREATMENT PROGRAM
SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

101.00 10100 HOME HEALTH AGENCY

113.00 11300 I NTEREST EXPENSE

200.00

201.00

202.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ADDODTIONMENT OF INDATIONS AN	ICLLLADY SERVICE CARLTAL COSTS   Dravidor CCN: 14 12	211 Pori od: Workshoot D

Heal th	Financial Systems	FAIRFIELD MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 10	pared:
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col . 26)	0.00	0.00	4.00		
	ANOLILARY OFFICE OF SOME	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0.0.477	0, ,0, 050		05/ /35	10.011	
	05000 OPERATI NG ROOM	362, 176				13, 014	
	05300 ANESTHESI OLOGY	0	- 1	0. 00000		Ĭ	
54.00	05400 RADI OLOGY-DI AGNOSTI C	151, 813	30, 928, 751	0. 00490			
60.00	06000 LABORATORY	105, 557	25, 027, 541	0. 00421			
65.00	06500 RESPI RATORY THERAPY	49, 571	4, 112, 750			•	
66. 00	06600 PHYSI CAL THERAPY	104, 959				•	
67.00	06700 OCCUPATI ONAL THERAPY	23, 906	•			•	
68. 00	06800 SPEECH PATHOLOGY	10, 170	•			1, 155	
69. 00	06900 ELECTROCARDI OLOGY	955	1, 778, 303				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	87, 648	11, 833, 721				
	07200 IMPL. DEV. CHARGED TO PATIENTS	29, 835					
	07300 DRUGS CHARGED TO PATIENTS	107, 572				11, 878	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	45, 929				0	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 00000	0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	795, 965				Ŭ	00.00
	09000 CLI NI C	281, 615				0	90.00
	09001 WOUND CARE	0	0	0. 00000		0	90. 01
	09002 PAIN CLINIC	4, 928		0. 03735		0	90. 02
	09003 UROLOGY CLINIC	114, 706	•			0	90. 03
	09100 EMERGENCY	161, 008				652	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	151, 546		0. 10109		0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0. 00000	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	2, 589, 859	138, 330, 160		6, 158, 445	57, 418	200. 00

Health Financial Systems	FAIRFIELD MEMORIAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1311	Peri od:	Worksheet D

From 07/01/2022 Part IV
To 06/30/2023 Date/Time Prepared: THROUGH COSTS 11/29/2023 10:22 am Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 54.00 06000 LABORATORY 0 0 60.00 0 60.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 C 0 76.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 90.00 09000 CLI NI C 0 0 90.00 90.01 09001 WOUND CARE 0 0 0 90.01 0 0 0 0 0 09002 PAIN CLINIC 0 90.02 0 0 90.02 0 09003 UROLOGY CLINIC 90.03 90.03 0 0 91.00 09100 EMERGENCY C 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 0 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 93.99 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

o

ol

0

o

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems FAIRFIELD MEM		L HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1311	Peri od:	Worksheet D
THROUGH COSTS			From 07/01/2022	Part IV

THROUGH COSTS 06/30/2023 Date/Time Prepared: To 11/29/2023 10:22 am Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 26, 624, 053 0.000000 50.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 53.00 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 30, 928, 751 54.00 54.00 0 0 0 25, 027, 541 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 4, 112, 750 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 3, 546, 652 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 788, 063 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 316, 432 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 778, 303 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 11, 833, 721 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 72.00 0 8, 672, 524 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 7, 568, 785 0.000000 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 1, 251, 705 0.000000 76.00 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77 00 0 0.000000 77 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 5, 178, 758 0.000000 88.00 90.00 09000 CLI NI C 0 0 0 0 0 811, 418 0.000000 90.00 09001 WOUND CARE 0 0 90 01 0.000000 90 01 09002 PAIN CLINIC 0 90.02 0 131, 922 0.000000 90.02 90.03 09003 UROLOGY CLINIC 739, 858 0.000000 90.03 0 0 91.00 09100 EMERGENCY 0 7, 519, 853 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92 00 Ω 1, 499, 071 0.000000 92.00 93.99 09399 PARTIAL HOSPITALIZATION PROGRAM 0.000000 93.99 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 0 0 200.00 Total (lines 50 through 199) 138, 330, 160 200.00

Health Financial Systems	FAIRFIELD MEMORIA	L HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1311	Peri od:	Worksheet D
THROUGH COSTS			From 07/01/2022	Part IV

THROUGH COSTS				rom 07/01/2022 Fo 06/30/2023		pared.	
				'	00, 00, 2020	11/29/2023 10	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	,					
	05000 OPERATING ROOM	0. 000000	956, 675	•	0	0	50.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	(	0	0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	563, 234		0	0	54.00
60.00	06000 LABORATORY	0. 000000	951, 584		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	858, 603		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	82, 980	(	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	63, 166	(	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	35, 927	(	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	84, 262	(	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	842, 292	(	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	853, 563	(	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	835, 701	(	0	0	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	(	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	(	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0	(	0	0	88. 00
90.00	09000 CLI NI C	0. 000000	0	(	0	0	90.00
90. 01	09001 WOUND CARE	0. 000000	0	(	0	0	90. 01
90.02	09002 PAIN CLINIC	0. 000000	0	(	0	0	90. 02
90.03	09003 UROLOGY CLINIC	0. 000000	0	(	0	0	90. 03
91.00	09100 EMERGENCY	0. 000000	30, 458	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	(	0	0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0	(	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		6, 158, 445	(	0	0	200. 00

Health Financial Systems	FAIRFIELD MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Prepared: 11/29/2023 10:22 am

					From 07/01/2022 To 06/30/2023	Part V   Date/Time Pre	narod:
					00/30/2023	11/29/2023 10	:22 am
			Title	XVIII	Hospi tal	Cost	
			<u> </u>	Charges	•	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00		0. 134680	0	7, 692, 919	9 0	0	50.00
53.00		0. 000000	0	1	, i	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 097129	0	11, 290, 637	0	0	54.00
60.00	06000 LABORATORY	0. 109373	0	8, 738, 809		0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 119575	0	976, 974		0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 397972	0	1, 242, 408		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 455493	0	56, 405		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 611316	0	28, 768	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 012210	0	782, 090		0	69. 00
71.00		0. 292220	0	3, 813, 723	0	0	71.00
72.00		0. 266014	0	2, 685, 300	0	0	72.00
73.00		0. 356700	0	2, 663, 393	2, 431	0	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 420899	0	708, 179	0	0	76. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	(	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC						88. 00
90.00		2. 477362	0	307, 343	0	0	90.00
90. 01	09001 WOUND CARE	0. 000000	0	(	0	0	90. 01
90. 02	09002 PAIN CLINIC	2. 501971	0	57, 051	0	0	90. 02
90. 03		1. 081207	0	329, 251	0	0	90. 03
91.00		0. 371523	0	2, 433, 539		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 929967	0	593, 721	0	0	92.00
93. 99		0. 000000	0	(	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0. 000000		(			95.00
200. 0			0	44, 400, 510	3, 094		200. 00
201.0					0		201. 00
	Only Charges						
202. 0	Net Charges (line 200 - line 201)		0	44, 400, 510	3, 094	0	202. 00

Health Financial Systems	FAIRFIELD MEMOR	DIAL HOSDITAL		In Lio	ı of Form CMS-2	0552 10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		Provi der C	CN: 14-1311	Peri od:	Worksheet D	.552-10
				From 07/01/2022 To 06/30/2023	Part V   Date/Time Pre   11/29/2023 10	pared: :22 am
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				

						11/29/2023 10	D: 22 am
			Title	XVIII	Hospi tal	Cost	
		Cos	ts				
Cost	Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
ANCI LLARY S	SERVICE COST CENTERS						
50. 00 05000 OPERA	TING ROOM	1, 036, 082	0	1			50.00
53. 00 05300 ANEST	HESI OLOGY	0	0				53.00
54. 00 05400 RADI 0	LOGY-DI AGNOSTI C	1, 096, 648	0				54.00
60. 00 06000 LABOR		955, 790	0	,			60.00
	RATORY THERAPY	116, 822	0	,			65.00
66. 00 06600 PHYSI		494, 444	0	,			66.00
1 1	ATI ONAL THERAPY	25, 692	0	,			67.00
68. 00 06800 SPEEC		17, 586	0	,			68.00
69. 00 06900 ELECT		9, 549	0				69.00
	AL SUPPLIES CHARGED TO PATIENTS	1, 114, 446	0				71.00
1 1	DEV. CHARGED TO PATIENTS	714, 327	0				72.00
	CHARGED TO PATIENTS	950, 032	867				73.00
	I ATRI C/PSYCHOLOGI CAL SERVI CES	298, 072	0	1			76.00
	ENEIC STEM CELL ACQUISITION	270, 072	0	1			77.00
	SERVICE COST CENTERS	<u> </u>		1			177.00
88. 00 08800 RURAL							88. 00
90. 00 09000 CLINI		761, 400	0				90.00
90. 01   09001   WOUND		701, 400	0				90.01
90. 02 09002 PAIN		142, 740	0				90.02
90. 03 09003 UROLO		355, 988	0				90.03
91. 00 09100 EMERG		904, 116	246				91.00
	VATION BEDS (NON-DISTINCT PART)	552, 141	0	1			92.00
	AL HOSPITALIZATION PROGRAM	332, 141	0	1			93. 99
	BURSABLE COST CENTERS	<u> </u>	0	1			73.77
95. 00 09500 AMBUL							95. 00
	tal (see instructions)	9, 545, 875	1, 113				200.00
	PBP Clinic Lab. Services-Program	7, 343, 673	1, 113				200.00
	Charges	ا					201.00
	harges (line 200 - line 201)	9, 545, 875	1, 113				202. 00
202.00   Net C	naiyes (iille 200 - iille 201)	9, 343, 8/5	1, 113	1			1202. UU

Health Financial Systems	FAIRFIELD MEMORIA	L HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1311 Component CCN: 14-5552	From 07/01/2022	Date/Time Prepared:
		T: +1 - V/// 1 1	Chi I I ad Novasi ass	11/29/2023 10: 22 am
		Title XVIII	Skilled Nursing	PPS

		Title	: XVIII	Skilled Nursing	PPS	
				Facility		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
ANOLILIADY OFFICE COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.101/00	_	T			
50. 00 05000 OPERATING ROOM	0. 134680			0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 097129	0		0	0	54.00
60. 00   06000   LABORATORY	0. 109373	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 119575			0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0. 397972	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 455493	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 611316	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 012210			0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 292220	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 266014	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 356700			0 2, 307	0	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 420899			0	0	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	,	T				
88.00 08800 RURAL HEALTH CLINIC						88. 00
90. 00   09000   CLI NI C	2. 477362	l e		0	0	90.00
90. 01 09001 WOUND CARE	0. 000000	0		0	0	90. 01
90. 02  09002   PAIN CLINIC	2. 501971	0		0	0	90. 02
90. 03   09003   UROLOGY CLI NI C	1. 081207	0		0	0	90. 03
91. 00  09100   EMERGENCY	0. 371523	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 929967	0		0	0	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0 0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)		0		0 2, 307	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)	[	0		0 2, 307	0	202. 00

Ith Financial Systems PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C		Peri od: From 07/01/2022	u of Form CMS- Worksheet D Part V	
		Component	CCN: 14-5552	To 06/30/2023	Date/Time Pro	epared 0: 22
		Title	XVIII	Skilled Nursing Facility	PPS	
	Cos	sts		T T GOTT T T		
Cost Center Description	(see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
00 05000 OPERATING ROOM	1 0	0				50.
00 05300 ANESTHESI OLOGY	0					53
00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54
00  06000   LABORATORY	0	0				60
00 06500 RESPIRATORY THERAPY	0	0				65
00 06600 PHYSI CAL THERAPY	0	0				66
00   06700   OCCUPATI ONAL THERAPY 00   06800   SPEECH PATHOLOGY		0				67
00   06900   SPEECH PATHOLOGY						69
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		Ö				71
00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö				72
00 07300 DRUGS CHARGED TO PATIENTS	0	823				73
00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77
OUTPATIENT SERVICE COST CENTERS	1	I	ı			4
00   08800   RURAL HEALTH CLINIC 00   09000   CLINIC	0	0				90
00   09000   CLINI C 01   09001   WOUND CARE		1				90
02   09002   PAIN CLINIC						90
03 09003 UROLOGY CLINIC	0	Ö				90
00 09100 EMERGENCY	0	0				91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1				92
99 09399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0	0				93
00 09500 AMBULANCE SERVICES	0	I.				95
0.00 Subtotal (see instructions)	0					200
Less PBP Clinic Lab. Services-Program	0	1				201
Only Charges		1	1			1

Health Financial Systems	FAIRFIELD MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 07/01/2022	Worksheet D Part I	
				To 06/30/2023	Date/Time Pre	pared:
		Ti +I	e XIX	Hospi tal	11/29/2023 10 Cost	: 22 am
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Di em	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	Auj ustilierit	Related Cost		col . 4)	
	B, Part II,		(col. 1 -		COI. 4)	
	col . 26)		col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	492, 285	C	492, 28	5 2, 576	191. 10	30.00
31.00 INTENSIVE CARE UNIT	30, 587	1	30, 58	7 105	291. 30	31.00
44.00 SKILLED NURSING FACILITY	406, 475		406, 47	5 7, 570	53. 70	44.00
200.00 Total (lines 30 through 199)	929, 347	1	929, 34	7 10, 251		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11	2, 102	2			30.00
31.00 INTENSIVE CARE UNIT	0	) C	)			31.00
44.00 SKILLED NURSING FACILITY	0	) C	)			44.00
200.00 Total (lines 30 through 199)	11	2, 102	2			200. 00

Health Financial Systems	FAIRFIELD MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2552-10
ABBORTI ON MENT OF LABORTI FAIT ANDLLIA	DV OFBUILDE OABLEAL GOOTS	D 1 1 00N 44 4044	n	W 1 1 1 D

Health Financial Systems	FAIRFIELD MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CA	PITAL COSTS	Provi der C		Period: From 07/01/2022 To 06/30/2023		
			e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.0.47.	1				
50. 00   05000   OPERATI NG ROOM	362, 176		0.00000		0	
53. 00 05300 ANESTHESI OLOGY	0		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	151, 813		0.00000		0	54.00
60. 00   06000   LABORATORY	105, 557		0.00000		0	60.00
65. 00 06500 RESPI RATORY THERAPY	49, 571		0.00000		0	65.00
66. 00 06600 PHYSI CAL THERAPY	104, 959		0.00000		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	23, 906		0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY	10, 170	-	0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	955		0.00000		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0.00000		0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	29, 835		0.00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	107, 572		0.00000		0	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	45, 929	1	0.00000		0	76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	705.045					
88. 00 08800 RURAL HEALTH CLINIC	795, 965		0.00000		0	
90. 00   09000   CLINIC	281, 615		0.00000		0	
90. 01   09001   WOUND CARE	4 000		0.00000		0	
90. 02   09002   PAIN CLINIC	4, 928		0.00000		0	90.02
90. 03   09003   UROLOGY   CLI NI C	114, 706		0.00000		0	90.03
91. 00 09100 EMERGENCY	161, 008		0.00000		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	151, 546	l .	0.00000		0	92.00
93. 99 O9399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	<u> </u>	0.00000	00 0	0	93. 99
OTHER REIMBURSABLE COST CENTERS		I	1			95. 00
95.00   09500   AMBULANCE SERVICES 200.00   Total (lines 50 through 199)	2 500 050		J	_	_	95.00 200.00
200.00   Total (lines 50 through 199)	2, 589, 859	[ C	'	0	1	J∠UU. UU

Total (lines 30 through 199)	Health Financial Systems	FAIRFIELD MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
Nursing Program Post-Stepdown Adjustments   Nursing Program Post-Stepdown Adjustments   Nursing Program Post-Stepdown Adjustments   Nursing Program Post-Stepdown Adjustments   Nursing Post-Stepdown Adjustment	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COS	TS Provider C		rom 07/01/2022	Part III	epared: 0:22 am
Program   Program   Program   Program   Program   Adjustments   Program   Pr			Ti tl	e XIX	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS   Adjustments   A	Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
NPATIENT ROUTINE SERVICE COST CENTERS   1		Program	Program	Post-Stepdown	Cost	Medi cal	
NPATI ENT ROUTINE SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0		Post-Stepdown		Adjustments		Educati on	
NPATI ENT ROUTI NE SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0		Adjustments				Cost	
0		1A	1. 00	2A	2. 00	3. 00	
Near   Structions   Stilled Nursing Service   Cost Center Description   Swing-Bed Adjustment Amount (see instructions)   Aut.   Stilled Nursing Service   Cost Center Description   Swing-Bed Adjustment Amount (see instructions)   Aut.   Stilled Nursing Service   Cost Center Description   Swing-Bed Adjustment   Sum of Cols.   Total Costs   Sum of Cols.   Swing-Bed Adjustment   Sum of Cols.   Amount (see instructions)   Aut.   Swing-Bed Adjustment   Sum of Cols.   Swing-Bed Adjustment   Swing-Be	INPATIENT ROUTINE SERVICE COST CENTERS						
Add	30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30.00
Total (lines 30 through 199)	31.00 03100 INTENSIVE CARE UNIT	0	0	(	0	0	31.00
Cost Center Description	44.00 04400 SKILLED NURSING FACILITY	0	0	(	0		44.00
Adjustment Amount (see instructions)   Adjustment Amount (see instructions)   Amount	200.00 Total (lines 30 through 199)	0	0	(	0	0	200.00
Amount (see instructions) minus col. 4)    Amount (see instructions) minus col. 4)   Col. 6)   Col. 6)	Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
INPATIENT ROUTINE SERVICE COST CENTERS   0   0.00		Adj ustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS		Amount (see	1 through 3,		col . 6)		
INPATIENT ROUTINE SERVICE COST CENTERS   0 0 0 2,576 0.00 11 30.00		instructions)	minus col. 4)				
30. 00   03000   ADULTS & PEDI ATRI CS   0   0   2,576   0.00   11   30.00   31.00   31.00   03100   INTENSI VE CARE UNI T   0   105   0.00   0   31.00   44.00   200.00   Total (lines 30 through 199)   11   200.00   Cost Center Description   Inpatient Program Pass-Through Cost (col. 7   x col. 8)   9.00		4. 00	5. 00	6. 00	7. 00	8. 00	
31. 00   03100   1NTENSI VE CARE UNI T   0   105   0.00   0   31. 00   44. 00   200. 00   Total (lines 30 through 199)   11   200. 00   Cost Center Description   Inpatient Program Pass-Through Cost (col. 7 x col. 8)   9.00   10   10   10   10   10   10   10							
44. 00	30.00   03000   ADULTS & PEDIATRICS	0	0	2, 570	0.00	11	30.00
Total (lines 30 through 199)   0   10, 251   11   200.00	31.00 03100 INTENSIVE CARE UNIT		0	105	0.00	0	31.00
Cost Center Description	44.00   04400   SKILLED NURSING FACILITY		0	7, 570	0.00	0	44.00
Program   Pass-Through   Cost (col. 7   x col. 8)   9.00			0	10, 25°	1	11	200.00
Pass-Through Cost (col. 7   x col. 8)   9.00	Cost Center Description	I npati ent					
Cost (col. 7   x col. 8)   9.00							
X COÎ . 8   9.00   9.00							
9.00    INPATIENT ROUTINE SERVICE COST CENTERS   30.00   31.00		Cost (col. 7					
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   3000   ADULTS & PEDIATRICS   0   30.00   31.00   03100   INTENSIVE CARE UNIT   0   31.00   44.00   04400   SKILLED NURSING FACILITY   0   44.00							
30. 00   03000   ADULTS & PEDI ATRI CS   0   30. 00   31. 00   03100   I NTENSI VE CARE UNI T   0   31. 00   44. 00   04400   SKI LLED NURSI NG FACI LI TY   0   44. 00   04400   CARE UNI T   0   04400   044		9. 00					
31. 00   03100   INTENSIVE CARE UNIT   0   44. 00   04400   SKILLED NURSING FACILITY   0   44. 00							
44. 00   04400   SKILLED NURSING FACILITY   0   44. 00							
200 00    Total (Lines 30 through 199)   0							
200.00   Total (This 30 through 177)	200.00   Total (lines 30 through 199)	0					200. 00

Health Financial Systems	FAIRFIELD MEMORIA	L HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1311	Peri od:	Worksheet D

From 07/01/2022 Part IV
To 06/30/2023 Date/Time Prepared: THROUGH COSTS 11/29/2023 10:22 am Title XIX Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 54.00 06000 LABORATORY 0 0 60.00 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 C 0 76.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 90.00 09000 CLI NI C 0 0 90.00 90.01 09001 WOUND CARE 0 0 0 90.01 0 0 0 0 0 09002 PAIN CLINIC 0 90.02 0 0 90.02 0 09003 UROLOGY CLINIC 90.03 90.03 0 0 91.00 09100 EMERGENCY C 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 0 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 93.99 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

o

ol

0

o

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	F ANCILLARY SERVICE OTHER PASS   Provider CCN: 14-131	
		From 07/01/2022   Dorst 11/

From 07/01/2022 | Part IV To 06/30/2023 | Date/Time Prepared: THROUGH COSTS 11/29/2023 10:22 am Title XIX Hospi tal Cost Cost Center Description All Other Total Cost Ratio of Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. 1, 2, 3, and 4) C, Part I, (col. 5 ÷ Educati on Cost (sum of Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 7. 00 4. 00 5.00 6.00 8. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0.000000 50.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53.00 53.00 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 0.000000 54.00 54.00 06000 LABORATORY 0 60.00 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0.000000 66.00 01 0 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 73.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 o 0.000000 76.00 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77 00 0 0.000000 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0.000000 88.00 09000 CLI NI C 0 90.00 0 0 0 0 0 0 0 0 0.000000 90.00 0 09001 WOUND CARE 0 90 01 0.000000 90 01 09002 PAIN CLINIC 0 90.02 0.000000 90.02 90. 03 09003 UROLOGY CLINIC 0 0 0.000000 90.03 0 0 91.00 09100 EMERGENCY 0 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92 00 Ω 0.000000 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 0 93.99 0 0.000000 93.99 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 o 0 0 0 200.00 Total (lines 50 through 199) 200.00

Health Financial Systems	FAIRFIELD MEMORIAL I	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATI THROUGH COSTS	ENT ANCILLARY SERVICE OTHER PASS P	Provider CCN: 14-1311	From 07/01/2022	Worksheet D Part IV

THROUG	in C0515				To 06/30/2023	Date/Time Pre	pared: 0:22 am
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS	T					
50.00	05000 OPERATING ROOM	0. 000000	0	)	0	0	00.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	)	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	)	0	0	54.00
60.00	06000 LABORATORY	0. 000000	0	)	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	0	)	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	0	)	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	)	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	)	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0	)	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	)	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	)	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0	)	0	0	73.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	1	0	0	76.00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	)	0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
	08800 RURAL HEALTH CLINIC	0. 000000	0	)	0	0	00.00
	09000 CLI NI C	0. 000000	0	)	0	0	90.00
90. 01	09001 WOUND CARE	0. 000000	0	)	0	0	90. 01
	09002 PAIN CLINIC	0. 000000	0	)	0	0	90. 02
	09003 UROLOGY CLINIC	0. 000000	0	)	0	0	90. 03
	09100 EMERGENCY	0. 000000	0	)	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	1	0	0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0 0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES		_		_	_	95.00
200.00	Total (lines 50 through 199)		0	ון	0 0	0	200.00

	Financial Systems FAIRFIELD MEMORIA			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 14-1311	Peri od: From 07/01/2022	Worksheet D-1	
			To 06/30/2023	Date/Time Pre 11/29/2023 10	
		Title XVIII	Hospi tal	Cost	. 22 aiii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			2 57/	1 1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			2, 576 2, 576	
3. 00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	1
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation	hed days)		1, 783	4.00
5. 00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost		1
6. 00	reporting period Total swing-bed SNF type inpatient days (including private r	nom davs) after December	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	doil days) after beceiliber	31 Of the cost	١	0.00
7. 00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	6			
9. 00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excludin	g swing-bed and	1, 113	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period	IX only (including priva	te room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar)			0	14. 00
15. 00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	rail (excruding swriig-bed	uays)	0	1
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17. 00
	reporting period	G			
18. 00	Medicare rate for swing-bed SNF services applicable to servine reporting period	ces after December 31 of	the cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	0. 00	19. 00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period		the cost		
21. 00 22. 00	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		ting period (line	4, 528, 575 0	21. 00 22. 00
22.00	5 x line 17)	iber 31 of the cost repor	tring perrou (irine		22.00
23. 00	] 3	er 31 of the cost reporti	ng period (line 6	0	23. 00
24. 00	x line 18)  Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24. 00
25 00	7 x line 19)	21 of the cost reportin	a ported (line 9		25 00
25. 00	Swing-bed cost applicable to NF type services after December $x$ line 20)	31 of the cost reportin	g period (iine 8	0	25. 00
26.00	,	(11 - 04 - 1 - 11 - 04)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 528, 575	27.00
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	1
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0 0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		ctions)	0. 00 0. 00	ı
35.00	Average per diem private room cost differential (line 34 x l	ine 31)	ĺ	0. 00	35. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		ifferential (lind	0 4, 528, 575	36. 00 37. 00
37.00	27 minus line 36)	and private room cost u	cicinciai (illie	7, 320, 373	37.00

12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00			17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	4, 528, 575	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line &	0	23.00
	x line 18)		
24. 00		0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26. 00		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 528, 575	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00		0. 00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	, , ,	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	4, 528, 575	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 757. 99	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 956, 643	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 956, 643	41.00

PUTATION OF INPATIENT OPERATING COST		Provi der Co	F	eriod: rom 07/01/2022	Worksheet D-1	
				o 06/30/2023	Date/Time Pre 11/29/2023 10	
01.01	T. L. I		XVIII	Hospi tal	Cost	
Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	Cost	Days	÷ col . 2)		col . 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
00 NURSERY (title V & XIX only)						42
Intensive Care Type Inpatient Hospital Units						
00 INTENSIVE CARE UNIT	103, 782	105	988. 40	42	41, 513	
OO CORONARY CARE UNIT						44
00 BURN INTENSIVE CARE UNIT						45
00   SURGICAL INTENSIVE CARE UNIT 00   OTHER SPECIAL CARE (SPECIFY)						46
Cost Center Description						47
2001 2001 2000 1 21 011					1. 00	
00 Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1, 257, 690	48
01 Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	0	
00 Total Program inpatient costs (sum of lines	41 through 48.(	01)(see instru	ctions)		3, 255, 846	49
PASS THROUGH COST ADJUSTMENTS						
OO Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50
OO Door through costs applicable to Drogram in	ationt anaille	ar comitoco (fi	com Wko+ D o	um of Donto II	0	_ E1
<pre>00 Pass through costs applicable to Program inp and IV)</pre>	atrent ancilia	y services (Ti	OIII WKSt. D, S	um OF PALES II	0	51
00 Total Program excludable cost (sum of lines	50 and 51)				0	52
00 Total Program inpatient operating cost exclu	,	elated, non-phy	ysician anesth	etist, and	0	
medical education costs (line 49 minus line						
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program discharges					0	
00 Target amount per discharge					0. 00	
O1 Permanent adjustment amount per discharge					0. 00	
02 Adjustment amount per discharge (contractor					0.00	
OO Target amount (line 54 x sum of lines 55, 55			! F/!	: [2)	0	1
00   Difference between adjusted inpatient operat 00   Bonus payment (see instructions)	ing cost and ta	arget amount (i	The 56 minus	The 53)	0	
00 Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	m the cost ren	orting period	andina 1006	0.00	
updated and compounded by the market basket)	of Title 55 Troil	ii the cost repo	of ting period	enuing 1990,	0.00	3,
00 Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior vear	cost report, u	odated by the	0. 00	60
market basket)		, , , ,				
OO Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	the amount by w	which operating	g costs (line	0	61
00 Relief payment (see instructions)					0	62
00 Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	`	<u> </u>				
00 Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64
instructions)(title XVIII only)					_	
00 Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65
instructions)(title XVIII only) 00   Total Medicare swing-bed SNF inpatient routi	no costs (lino	44 plus lino	4E) (+; +1 ~ V\// I	only), for	0	66
CAH, see instructions	ne costs (Title	04 prus rine (	os)(title xvii	on y), roi	U	1 00
00 Title V or XIX swing-bed NF inpatient routin	e costs throuah	n December 31 o	of the cost re	porting period	0	67
(line 12 x line 19)	· ·			0 .		
OO Title V or XIX swing-bed NF inpatient routin	e costs after [	December 31 of	the cost repo	rting period	0	68
(line 13 x line 20)	moutles side	(line /7   !!	. (0)		_	1,
OD Total title V or XIX swing-bed NF inpatient		`			0	69
PART III - SKILLED NURSING FACILITY, OTHER N OO Skilled nursing facility/other nursing facil						70
00 Adjusted general inpatient routine service c						71
00 Program routine service cost (line 9 x line			,			72
00 Medically necessary private room cost applic		m (line 14 x li	ne 35)			73
00 Total Program general inpatient routine serv						74
OO Capital-related cost allocated to inpatient	routine service	e costs (from N	Worksheet B, Pa	art II, column		75
26, line 45)	no 2)					-,
00   Per diem capital-related costs (line 75 ÷ li 00   Program capital-related costs (line 9 x line						76
00 Inpatient routine service cost (line 74 minu	•					78
00 Aggregate charges to beneficiaries for exces		orovi der record	ds)			79
00 Total Program routine service costs for comp				us line 79)		80
00 Inpatient routine service cost per diem limi				/		81
00 Inpatient routine service cost limitation (I		1)				82
OO Reasonable inpatient routine service costs (		ns)				83
00 Program inpatient ancillary services (see in						84
00 Utilization review - physician compensation						85
OD Total Program inpatient operating costs (sum		nrough 85)				86
PART IV - COMPUTATION OF OBSERVATION BED PASS					793	
00   Total observation bed days (see instructions						

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL In Lieu					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		
Title XVIII Hospital					Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			1, 394, 086	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	492, 285	4, 528, 575	0. 10870	6 1, 394, 086	151, 546	90.00
91.00 Nursing Program cost	0	4, 528, 575	0.00000	1, 394, 086	0	91.00
92.00 Allied health cost	o	4, 528, 575	0.00000	1, 394, 086	0	92.00
93.00 All other Medical Education	o	4, 528, 575	0. 00000	1, 394, 086	0	93. 00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1311	Peri od:	Worksheet D-1
	Component CCN: 14-5552	From 07/01/2022	
	Component Con. 14-3332	10 00/30/2023	11/29/2023 10: 22 am
	Title XVIII	Skilled Nursing	PPS
		Facility	

		Facility		
	Cost Center Description		1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days		7, 570	
2.00	Inpatient days (including private room days, excluding swing-		7, 570	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only private room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)	7, 570	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro			5.00
	reporting period			
6. 00	Total swing-bed SNF type inpatient days (including private roomstrang paried (if colonder year enter 0 on this line)	om days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December 31 of the cost	0	7.00
7.00	reporting period	iii days) thi ough becomber 31 of the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding swing-bed and	1, 108	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instruc			10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		0	11.00
40.00	December 31 of the cost reporting period (if calendar year, e			40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including private room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XII	X only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye			10.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)		0	
16. 00	Nursery days (title V or XIX only)		0	16.00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 of the cost		17. 00
17.00	reporting period	es through becomber 51 of the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of the cost		18. 00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of the cost	0.00	19. 00
20 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the cost	0.00	20.00
20.00	reporting period		0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions		3, 361, 390	
22. 00	Swing-bed cost applicable to SNF type services through December 173	er 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting period (line	0	23.00
23.00	x line 18)	of the cost reporting perrou (Time t	ĺ	23.00
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporting period (line	0	24.00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting period (line 8	0	25. 00
26 00	Total swing-bed cost (see instructions)		0	26.00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	3, 361, 390	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
	General inpatient routine service charges (excluding swing-bed	d and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)		0	1
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 28)	0. 000000	30.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- Title 20)	0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34.00	Average per diem private room charge differential (line 32 mi)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line	ne 31)	0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost differential (lin	2 261 200	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost differential (IIN)	3, 361, 390	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			†
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see	*		38. 00
39.00	Program general inpatient routine service cost (line 9 x line	· ·		39.00
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			40. 00 41. 00
<del>-</del> 1. 00	Total Trogram general impatrent routine service cost (IIIIe 37	11110 70)	I	1 -1.00

MPUT	Financial Systems ATION OF INPATIENT OPERATING COST	FAIRFIELD MEMOR	Provi der C	CN: 14-1311	Peri od:	u of Form CMS-2 Worksheet D-1	
			Component	CCN: 14-5552	From 07/01/2022 To 06/30/2023	Date/Time Pre	
			Title	e XVIII	Skilled Nursing	11/29/2023 10 PPS	): 22
	Cost Center Description	Total	Total	Average Per	Facility Program Days	Program Cost	
	222	Inpatient Cost	Inpatient Days	Diem (col. + col. 2)	3	(col. 3 x col. 4)	
00	NUDCEDY (+; +l o V * VIV only)	1. 00	2. 00	3.00	4. 00	5. 00	42
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.
00	INTENSIVE CARE UNIT						43.
.00	CORONARY CARE UNIT						44.
.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1. 00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1.00	48.
01	Program inpatient cellular therapy acquisiti			III, line 10	), column 1)		48.
00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instru	ctions)			49
.00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D si	ım of Parts I and		50.
00	III)	atrent reatine	301 11 003 (11 0	iii iikst. b, s	am or rares r and		
00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II		51.
00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52
00	Total Program inpatient operating cost exclu	,	elated, non-ph	ysician anes	thetist, and		53
	medical education costs (line 49 minus line	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54
00	Target amount per discharge						55
01	Permanent adjustment amount per discharge						55
02	Adjustment amount per discharge (contractor						55
00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	s line 53)		56
00	Bonus payment (see instructions)	ing cost and to	inger amount (		7 TTHE 60)		58
00	Trended costs (lesser of line 53 ÷ line 54,		n the cost rep	orting period	d ending 1996,		59
00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year	cost report	undated by the		60
00	market basket)	of Time 33 fre	m prior year	cost report,	updated by the		00
00	Continuous improvement bonus payment (if lir						61
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)		the target a		, o, , o to oo		
	Relief payment (see instructions)						62
00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)				63
00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of th	e cost repor	ting period (See		64
00	instructions)(title XVIII only)	. +£+ D	21 -6 -6-		(6		/ _
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 or the	cost reportir	ig period (see		65
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XV	<pre>II only); for</pre>		66
00	CAH, see instructions	o costo the	Docombo = 24	of the	conorting rest		, -
00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ie costs inrough	December 31	or the cost I	eporting period		67
00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost re	oorting period		68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (	line 47 : Lim	a 68)			69
JU	PART III - SKILLED NURSING FACILITY, OTHER N						1 09
00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 3	7)	3, 361, 390	
00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)		444. 04	
00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	ı (line 14 x l	ine 35)		491, 996 0	1
00	Total Program general inpatient routine serv					491, 996	
00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column	0	75
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				0.00	76
00	Program capital -related costs (line 9 x line					0.00	1
00	Inpatient routine service cost (line 74 minu	ıs line 77)				0	78
00	Aggregate charges to beneficiaries for exces				nue Line 70)	0	
00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JOST IIMITATIO	ıı (ııne /8 mı	nus iine 79)	0 0. 00	
00	Inpatient routine service cost per diem frum		)			0.00	1
00	Reasonable inpatient routine service costs (	see instruction				491, 996	1
00	Program inpatient ancillary services (see in		une)			381, 265	
00	Utilization review - physician compensation					0 873, 261	
00	Total Program inpatient operating costs (sum		ii uuuri aar				

Health Financial Systems	FAIRFIELD MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 14-5552	From 07/01/2022 To 06/30/2023		pared: :22 am
		Title	XVIII	Skilled Nursing	PPS	
	Facility					
Cost Center Description						
	1. 00					
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	: line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	ee instructions)	)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	0	0	0. 00000	0 0	0	90.00
91.00 Nursing Program cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	00	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00

Heal th	Financial Systems FAIRFIELD MEMORIA	AL HOSPITAL	In lie	u of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST	Provider CCN: 14-1311	Peri od:	Worksheet D-1		
	From 07/01/2022 To 06/30/2023					
		Title XIX	Hospi tal	11/29/2023 10 Cost		
	Cost Center Description			4 00		
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	I NPATI ENT DAYS					
1. 00	Inpatient days (including private room days and swing-bed day			2, 576	1.00	
2. 00 3. 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d		rivata room days	2, 576 0	2. 00 3. 00	
3.00	do not complete this line.	ays). If you have only p	irvate room days,	U	3.00	
4.00	Semi-private room days (excluding swing-bed and observation			1, 783	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private responsible partial	oom days) through Decemb	er 31 of the cost	0	5. 00	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private re	oom davs) after December	31 of the cost	0	6. 00	
	reporting period (if calendar year, enter 0 on this line)			_		
7. 00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7. 00	
8. 00	reporting period Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	or or the cost	· ·	0.00	
9. 00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	11	9. 00	
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10. 00	
10.00	through December 31 of the cost reporting period (see instru	3 · 3 ·	room days)	O	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11. 00	
12. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		to room days)	0	12. 00	
12.00	through December 31 of the cost reporting period	ix only (including priva	te room days)	O	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	ralli (excruding swrng-bed	uays)	0	15.00	
16.00	Nursery days (title V or XIX only)			0	16. 00	
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	cos through Docombon 21	of the cost		17. 00	
17.00	reporting period	ces till ought becember 31	of the cost		17.00	
18. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18. 00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19. 00	
17.00	reporting period	es through becomber 51 o	the cost	0.00	17.00	
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0. 00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instruction	ne)		4, 528, 575	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December		ting period (line		22.00	
	5 x line 17)			_		
23. 00	Swing-bed cost applicable to SNF type services after Decembe $x$ line 18)	r 31 of the cost reporti	ng period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24. 00	
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reportin	a ported (line 9	0	25. 00	
23.00	x line 20)	31 of the cost reportin	g perrod (Trile o	O	25.00	
26. 00	Total swing-bed cost (see instructions)			0	26.00	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 528, 575	27. 00	
28. 00	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0	29.00	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	± line 28)		0. 000000	30. 00 31. 00	
31.00	Average private room per diem charge (line 29 ÷ line 3)	- IIIIC 20)		0.00000		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00		
34.00	Average per diem private room charge differential (line 32 m		ctions)	0.00		
35. 00 36. 00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	35. 00 36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-		

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 576	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 576	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	o	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 783	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
0.00	reporting period	ĭ	0.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	ĭ	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	ĭ	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٩	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	11	9. 00
9.00	newborn days) (see instructions)	''	9.00
10.00		0	10.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	٩	10.00
11 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11 00
11. 00		٩	11. 00
12.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12 00	through December 31 of the cost reporting period		12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		4
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	4, 528, 575	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 🛭	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	o	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	o	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 528, 575	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00			
	Private room charges (excluding swind-bed charges)	()]	29 00
	Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)	0	29. 00 30. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0 0. 000000	30. 00 31. 00
30. 00 31. 00 32. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0 0. 000000 0. 00	30. 00 31. 00 32. 00
30. 00 31. 00 32. 00 33. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0.000000 0.00 0.00 0.00	30. 00 31. 00 32. 00 33. 00
30. 00 31. 00 32. 00 33. 00 34. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 000000 0. 00 0. 00 0. 00 0. 00	30. 00 31. 00 32. 00 33. 00 34. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0.000000 0.00 0.00 0.00	30.00 31.00 32.00 33.00 34.00 35.00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0. 000000 0. 000 0. 00 0. 00 0. 00 0. 00	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0. 000000 0. 00 0. 00 0. 00 0. 00	30.00 31.00 32.00 33.00 34.00 35.00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0. 000000 0. 000 0. 00 0. 00 0. 00 0. 00	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	0. 000000 0. 000 0. 00 0. 00 0. 00 0. 00	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	0 0.000000 0.00 0.00 0.00 0.00 4,528,575	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 4, 528, 575	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	0 0.000000 0.00 0.00 0.00 0.00 4,528,575	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	0 0.000000 0.00 0.00 0.00 0.00 0 4,528,575 1,757.99 19,338 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	0.000000 0.000 0.00 0.00 0.00 0.00 0 4,528,575	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1311			Worksheet D-1				
				To 06/30/2023	Date/Time Prepared				
		Ti tle XIX		Hospi tal	11/29/2023 10 Cost	): 22 am			
Cost Center Description	Total Inpati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)				
42.00 NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00			
Intensive Care Type Inpatient Hospital Un		2 105 988, 40							
43.00   INTENSIVE CARE UNIT 44.00   CORONARY CARE UNIT	103, 782	105	988. 4	0	43.00				
45.00 BURN INTENSIVE CARE UNIT						45.00			
46.00   SURGICAL INTENSIVE CARE UNIT 47.00   OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00			
Cost Center Description						47.00			
48.00 Program inpatient ancillary service cost		1. 00	48.00						
48.01 Program inpatient cellular therapy acquis	ition cost (Works	neet D-6, Part		column 1)	0 19, 338	48. 01			
49.00 Total Program inpatient costs (sum of lin PASS THROUGH COST ADJUSTMENTS	00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)								
III)	innotiont oncillo	nu comul coo (f	From What D	oum of Dorsto II	0	51.00			
51.00 Pass through costs applicable to Program and IV)									
52.00 Total Program excludable cost (sum of lin					0				
53.00 Total Program inpatient operating cost ex medical education costs (line 49 minus li	0 .	erated, non-pr	nysician anesti	netist, and	0	53.00			
TARGET AMOUNT AND LIMIT COMPUTATION									
54.00 Program di scharges 55.00 Target amount per di scharge					0 0. 00				
, , , , , , , , , , , , , , , , , , , ,	Adjustment amount per discharge (contractor use only)								
9									
58.00 Bonus payment (see instructions)	00 Bonus payment (see instructions)								
59.00 Trended costs (lesser of line 53 ÷ line 5 updated and compounded by the market bask	0. 00	59.00							
60.00 Expected costs (lesser of line 53 ÷ line	0. 00	60.00							
market basket) 61.00 Continuous improvement bonus payment (if 55.01, or line 59, or line 60, enter the	0	61.00							
53) are less than expected costs (lines 5 enter zero. (see instructions)	4 x 60), or 1 % or	f the target a	mount (line 5	6), otherwise					
62.00 Relief payment (see instructions)	0	62.00							
63.00 Allowable Inpatient cost plus incentive p	0	63.00							
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine	0	64.00							
instructions)(title XVIII only)									
65.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	0	65.00							
66.00 Total Medicare swing-bed SNF inpatient ro	0	66.00							
CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient rou	0	67.00							
(line 12 x line 19)	_								
68.00   Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	0	68.00							
69.00 Total title V or XIX swing-bed NF inpatie	0	69.00							
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing fa				)		70.00			
71.00 Adjusted general inpatient routine servic	e cost per diem (			,		71. 00 72. 00			
· ·	ogram routine service cost (line 9 x line 71)								
	necessary private room cost applicable to Program (line 14 x line 35) ogram general inpatient routine service costs (line 72 + line 73)								
75.00 Capital-related cost allocated to inpatie 26, line 45)	pital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column								
76.00 Per diem capital-related costs (line 75 ÷	line 2)					76.00			
77.00 Program capital-related costs (line 9 x l		77. 00 78. 00							
80.00 Total Program routine service costs for c	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								
81.00  Inpatient routine service cost per diem   82.00  Inpatient routine service cost limitation		81.00 82.00							
1 .	, ,								
	00 Program inpatient ancillary services (see instructions)								
85.00  Utilization review - physician compensati 86.00  Total Program inpatient operating costs (						85. 00 86. 00			
PART IV - COMPUTATION OF OBSERVATION BED 87.00 Total observation bed days (see instructi	PASS THROUGH COST	· /				1			
	ons )				793	87.00			

Health Financial Systems	FAIRFIELD MEMOR	RIAL HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	Provider CCN: 14-1311		Worksheet D-1	
					Date/Time Prepared: 11/29/2023 10:22 am	
		Ti tle XIX		Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	1, 394, 086	89.00				
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH						
90.00 Capital -related cost	492, 285	4, 528, 575	0. 10870	1, 394, 086	151, 546	90.00
91.00 Nursing Program cost	0	4, 528, 575	0. 00000	1, 394, 086	0	91.00
92.00 Allied health cost	0	4, 528, 575	0. 00000	1, 394, 086	0	92.00
93.00 All other Medical Education	0	4, 528, 575	0. 00000	00 1, 394, 086	0	93.00

NPATI EN	IT ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Pre 11/29/2023 10	parec
		Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x	
					col . 2)	
	IDATI ENT. DOUTING OFFINASE OFFINASE		1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1			4
	3000 ADULTS & PEDI ATRI CS			1, 671, 438		30.
	3100   NTENSI VE CARE UNIT			103, 916		31.
	NCILLARY SERVICE COST CENTERS		0.404//	20 057 775	100.045	
	5000 OPERATING ROOM		0. 13468		128, 845	
	5300  ANESTHESI OLOGY 5400  RADI OLOGY-DI AGNOSTI C		0. 00000 0. 09712		0 E4 704	
	6000 LABORATORY		0.09712		54, 706 104, 078	
	6500 RESPI RATORY THERAPY		0. 1093		104, 078	
	6600 PHYSI CAL THERAPY		0. 1195		33, 024	
	6700 OCCUPATI ONAL THERAPY		0. 45549		28, 772	
	6800 SPEECH PATHOLOGY		0. 4554		21, 963	
	6900 ELECTROCARDI OLOGY		0.0113		1, 029	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 29222		246, 135	
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 2660		227, 060	
	7300 DRUGS CHARGED TO PATIENTS		0. 35670		298, 095	
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 42089		0	
	7700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000		0	
	JTPATIENT SERVICE COST CENTERS		0.0000	50		1
	3800 RURAL HEALTH CLINIC		0.00000	00	0	T 88.
	9000 CLI NI C		2. 47736		0	90.
0. 01   09	9001 WOUND CARE		0. 00000	00	0	90.
0. 02 09	9002 PAIN CLINIC		2. 5019	71 0	0	90.
0. 03 09	9003 UROLOGY CLINIC		1. 08120	07	0	90.
1.00 09	9100 EMERGENCY		0. 37152	23 30, 458	11, 316	
2.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 92996	67 0	0	92.
3. 99 09	9399 PARTIAL HOSPITALIZATION PROGRAM		0. 00000	00	0	93.
	THER REIMBURSABLE COST CENTERS					
. 00 09	9500 AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			6, 158, 445	1, 257, 690	200.
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00	Net charges (line 200 minus line 201)		[	6, 158, 445		202.

	FI NANCI LLARY SERVICE COST APPORTIONMENT  FAIRFIELD MEMORI	Provi der C	CN: 14-1311	Peri od:	Worksheet D-3	
		Component	CCN: 14-5552	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 10	
		Title	· XVIII	Skilled Nursing		. ZZ dili
				Facility		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31.00
	ANCILLARY SERVICE COST CENTERS		•	_	•	1
50. 00	05000 OPERATING ROOM		0. 13468	30 0	0	50.00
53.00	05300 ANESTHESI OLOGY		0. 00000	00	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 09712	9, 321	905	54.00
50.00	06000 LABORATORY		0. 10937	·		
65.00	06500 RESPI RATORY THERAPY		0. 11957			
	06600 PHYSI CAL THERAPY		0. 39797		103, 788	
67. 00	06700 OCCUPATI ONAL THERAPY		0. 45549		138, 177	
	06800 SPEECH PATHOLOGY		0. 61131			
	06900 ELECTROCARDI OLOGY		0. 01221			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 29222		7, 378	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0. 26601		0 217	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 35670 0. 42089		90, 217 0	1
	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0. 00000			
	OUTPATIENT SERVICE COST CENTERS		0.00000	0	0	177.00
	08800 RURAL HEALTH CLINIC		0.00000	00	0	88.00
	09000 CLINIC		2. 47736		1	
	09001 WOUND CARE		0.00000		Ō	1
	09002 PAIN CLINIC		2. 50197		0	1
90. 03	09003 UROLOGY CLINIC		1. 08120	07	0	90.03
91. 00	09100 EMERGENCY		0. 37152	23 0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 92996	57 0	0	92.00
	09399 PARTIAL HOSPITALIZATION PROGRAM		0.00000	00 0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95.00
200. 00				1, 028, 804		
201.00		es (line 61)		0	l	201.00
202.00	Net charges (line 200 minus line 201)		1	1, 028, 804		202.00

	nancial Systems FAIRFIELD MEN ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 11_1311	Peri		u of Form CMS-2 Worksheet D-3	
INIAIILNI	ANCIELARI SERVICE COST ALTORITORINENT	i i ovi dei c	ON. 14-1311		n 07/01/2022	WOLKSHEET D-3	
				То	06/30/2023	Date/Time Pre 11/29/2023 10	pared:
		Ti tl	e XIX		Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpatient	I npati ent	
			To Charges	;	Program	Program Costs	
					Charges	(col. 1 x	
						col . 2)	
			1.00		2. 00	3. 00	
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS				0		30.00
	00 INTENSIVE CARE UNIT				0		31.00
	ILLARY SERVICE COST CENTERS				. 1		
	OO OPERATI NG ROOM		0.0000		0	0	50.00
	00 ANESTHESI OLOGY		0.0000		0	0	53.00
	00 RADI OLOGY-DI AGNOSTI C		0.0000		0	0	54.00
	00 LABORATORY		0.0000		0	0	60.00
	00 RESPI RATORY THERAPY		0.0000		0	0	65.00
	00 PHYSI CAL THERAPY		0.0000		0	0	66.00
	00 OCCUPATI ONAL THERAPY		0.0000		0	0	67.00
	00 SPEECH PATHOLOGY		0.0000		0	0	68.00
	00 ELECTROCARDI OLOGY		0.0000		0	0	69.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	0	71.00
	00 IMPL. DEV. CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS		0. 0000 0. 0000		0	0	72.00 73.00
	50  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		ol Ol	0	76.00
	OO ALLOGENEIC STEM CELL ACQUISITION		0.0000		ol Ol	0	77.00
	PATIENT SERVICE COST CENTERS		0.0000		U <sub>I</sub>	U	177.00
	OO RURAL HEALTH CLINIC		0.0000	100	O	0	88.00
	OO CLINIC		0.0000		0	0	90.00
	01 WOUND CARE		0.0000			0	90.01
	02 PAIN CLINIC		0.0000		0	0	90.02
	03 UROLOGY CLINIC		0.0000		0	0	90.03
	OO EMERGENCY		0.0000		0	0	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)		0.0000		o	0	92.00
	99 PARTIAL HOSPITALIZATION PROGRAM		0.0000		0	0	93. 99
	ER REIMBURSABLE COST CENTERS		2. 2000				1,
	00 AMBULANCE SERVICES						95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98	)			0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only ch				o	ŭ	201.00
202.00	Net charges (line 200 minus line 201)	3 - (			o		202.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/29/2023 10:22 am

-	Title XVIII Hospi	tal	11/29/2023 10 Cost	: 22 am
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1. 00	Medical and other services (see instructions)		9, 546, 988	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS or REH payments		0	3.00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5. 00
6. 00	Line 2 times line 5		0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions			9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		9, 546, 988	
	COMPUTATION OF LESSER OF COST OR CHARGES			
12 00	Reasonable charges			12 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	12. 00 13. 00
14. 00			Ö	14. 00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge		1	15.00
16. 00	Amounts that would have been realized from patients liable for payment for services on a charge had such payment been made in accordance with 42 CFR §413.13(e)	gebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)		0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (s	see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (s	see	o	20. 00
20.00	instructions)	300		20.00
21. 00	Lesser of cost or charges (see instructions)		9, 642, 458	
22. 00	Interns and residents (see instructions)		0	22.00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instructions)  Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)		127, 304	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6, 962, 171	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] instructions)	(see	2, 552, 983	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		o	28. 00
28. 50	REH facility payment amount			28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30. 00 31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments		2, 552, 983 994	
32. 00			2, 551, 989	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00			0	
34. 00 35. 00			953, 792 619, 965	
	Allowable bad debts for dual eligible beneficiaries (see instructions)		739, 248	
	Subtotal (see instructions)		3, 171, 954	
			0	
39. 00	· · · · · · · · · · · · · · · · · · ·		0	39. 00
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)		o	39. 50 39. 75
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)		3, 171, 954 63, 439	
40. 01			03, 437	40. 01
40. 03	Sequestration adjustment-PARHM pass-throughs			40. 03
41.00	· ·		3, 523, 929	
41. 01	Interim payments-PARHM		o	41. 01 42. 00
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)		0	42.00
43. 00	, ,,,		-415, 414	
43. 01	Balance due provider/program-PARHM (see instructions)			43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter	1,	333, 827	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)		0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
	The rate used to calculate the Time Value of Money		1	92.00
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)		0	93. 00 94. 00
71.00	1.0 tal. (58.11.105 )1 talia 70)		١	71.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Pre 11/29/2023 10	
	Title XVIII	Hospi tal	Cost	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1311	Peri od:	Worksheet E
	Component CCN: 14-5552	From 07/01/2022	
	Component Con: 14-5552	10 06/30/2023	11/29/2023 10: 22 am
	Title XVIII	Skilled Nursing	PPS
		Facility	

Medical and other services freinbursed under OPPS (see instructions)   2 0.0		Facility		
MART R WENDER MAY OTHER HEATH SERVICES			1 00	
2.00   2.00		PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
3.00   OPTS or REH payment (see instructions)		, , , , , , , , , , , , , , , , , , ,		1.00
4.00   Outlier payment (see instructions)   4.00   Outlier reconcilistion immunit (see instructions)   4.00   Outlier reconcilistion immunit (see instructions)   4.00   Outlier reconcilistion immunit (see instructions)   4.00   Outlier payment (see instructions)   4.00   Outlier paym		· · · · · · · · · · · · · · · · · · ·	0	
4.01   Auril or   record				
Infrare the hospital specific payment to cost ratio (see instructions)		, , , , , , , , , , , , , , , , , , , ,		4. 01
Sum of Fines 3, 4, and 4, 01, divided by Fine 6   0.00   7.00	5.00	, , ,		5.00
1.   Transit timal corridor payment (see instructions)   0   8.00			-	6.00
Ancillary service other pass through costs from West D, Pt. IV, col. 13, line 200				
10.00   Organ acquisitions   20   10.00   10				
Computation of Lesser OF COST OR CHARGES   Reasonable   Reasonable charges   Reasonable   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges   Reasonable charges   R				10.00
Reasonable charges	11. 00		823	11. 00
12.00   Ancil Harry service charges   2,307   12.00   13.00				
13.00   Organ acquisit tion charges (From Wist. D-4, Pt. III, col. 4, line 69)   0   13.00	12. 00	ÿ	2, 307	12.00
Customary charges  Los Outpergreta amount actually collected from patients liable for payment for services on a charge basis on 15.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis on 16.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis on 16.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis on 16.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis on 16.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis on 16.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis on 16.00 Anounts for liable for payment for services on a chargebasis on 16.00 Anounts for liable for payment for services on a chargebasis on 16.00 Anounts for liable for payment for services in a feet of payment for services in a feet in service for services in a feet of payment for services in a feet of p				13.00
15.00   Aggregate amount actually collected from patients   Iable for payment for services on a charge basis   0   15.00	14.00		2, 307	14.00
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   nature	15 00		0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)				
18.00   Total customary charges (see instructions)   2,307   18.00   20.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see Instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)   20.00   Excess of cost or charges (see instructions)   22.00   Cost of physicians services in a teaching hospital (see instructions)   0.22,00   23.00   23.00   25.	10.00	· · · · · · · · · · · · · · · · · · ·	Ü	10.00
19.00   Excess of customary charges over reasonable cost (complete only if fine 18 exceeds line 11) (see instructions)   1.484   9,00		, ,		17. 00
Instructions    2				
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   instructions)   823   21.00   22.00   22.00     22.00	19.00		1, 484	19.00
Instructions	20. 00	, ,	0	20. 00
22.00   Interns and residents (see instructions)   0 22.00		instructions)		
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0   24.00   0   04.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   0   24.00   0   04.00   05.0				21.00
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   24.00   COMPUTATION OF REINBURSEMENT STITLEMENT		, ,		
COMPUTATION OF RELIMBURSEMENT SETTLEMENT				
26. 00         Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)         26. 00           27. 00         Subtotal E(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)         823 27. 00           28. 00         Direct graduate medical education payments (from Wkst. E-4, line 50)         0         28. 00           29. 00         ESRD direct medical education costs (from Wkst. E-4, line 36)         0         29. 00           30. 00         Subtotal (sum of lines 27, 28, 28.50 and 29)         823         30. 00           31. 00         Primary payer payments         0         31. 00           30. 00         Subtotal (line 30 minus line 31)         823         32.           4LLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         823         32.           34. 00         All owable bad debts (see instructions)         0         33. 00           36. 00         All owable bad debts (see instructions)         0         36. 00           37. 00         Subtotal (see instructions)         0         36. 00           38. 00         WBP-LCC reconciliation amount from PS&R         38. 00           39. 00         WBP-LCC reconciliation amount from pyment adjustment (see instructions)         0         39. 00           39. 79         Pomostration				
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   28.00   2			0	25.00
instructions			012	
28. 00       Direct graduate medical education payments (from Wkst. E-4, line 50)       28. 05         28. 50       REFH facility payment amount       28. 50         29. 00       ESRD direct medical education costs (from Wkst. E-4, line 36)       0       29. 00         30. 00       Subtotal (sum of lines 27, 28, 28. 50 and 29)       823       30. 00         31. 00       Pirmary payer payments       0       31. 00         32. 00       Subtotal (line 30 minus line 31)       823       32. 00         33. 00       Composite rate ESRD (from Wkst. I -5, line 11)       0       33. 00         34. 00       All owable bad debts (see instructions)       0       34. 00         35. 00       Adjusted reimbursable bad debts (see instructions)       0       35. 00         36. 00       All lowable bad debts for dual elligible beneficiaries (see instructions)       0       35. 00         38. 00       MSP-LCC reconcilitation amount from PS&R       823       37. 00         39. 00       Differ ADJUSTRENTS (SEE InSTRUCTIONS) (SPECIFY)       39. 00       39. 00         39. 57       Posespirator payment adjustment amount (see instructions)       39. 57         39. 97       Demonstration payment adjustment amount elevations       39. 97         39. 98       Pactual or full credits received from manufactur	27.00		023	27.00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   3ubtotal (sum of lines 27, 28, 28.50 and 29)   823   30.00   31.00   7 mary payer payments   0.31.00   31.00   823   32.00   823	28.00	, ,	0	28.00
30. 00   Subtotal (sum of lines 27, 28, 28.50 and 29)   823   30. 00   31. 00   31. 00   31. 00   32. 00   32. 00   Subtotal (line 30 minus line 31)   823   32. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   34. 00			_	28. 50
31.00   Primary payer payments   0   31.00   Subtotal (line 30 minus line 31)   823   32.00		· · · · · · · · · · · · · · · · · · ·		
Subtotai (1 ine 30 minus line 31)				
33.00   Composite rate ESRD (from Wist. I - 5, line 11)   0   33.00   All owable bad debts (see instructions)   0   34.00   34.00   All owable bad debts (see instructions)   0   35.00   35.00   All owable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   823   37.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Poneer ACO demonstration payment adjustment (see instructions)   0   39.50   75.00   39.50   75.00				32.00
34.00		,		
35.00				
36.00		, , , , , , , , , , , , , , , , , , ,		
38.00 MSP-LCC reconciliation amount from PS&R 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.90 Pi oneer ACO demonstration payment adjustment (see instructions) 0 39.00 39.75 N95 respirator payment adjustment amount (see instructions) 0 39.75 Demonstration payment adjustment amount before sequestration 0 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 N90 N90 N90 Subtotal (see instructions) 16 40.01 Sequestration adjustment (see instructions) 16 40.01 Sequestration adjustment (see instructions) 16 40.01 Interim payment adjustment amount after sequestration 17 Interim payments N90 N90 Interim payments N90				36.00
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   39.00   39.00   39.00   39.50   39.			823	
39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 75 N95 respirator payment adjustment amount (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 97 Demonstration payment adjustment amount before sequestration 39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 98 ACCOVERY OF ACCELERATED DEPRECIATION 39. 99 ACCOVERY OF ACCELERATED DEPRECIATION 39. 90 ACCELERATED DE				
39.75 39.97 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.98 40.00 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment (see instructions) 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment (see instructions) 40.05 Sequestration adjustment amount after sequestration 40.06 Sequestration adjustment—PARHM pass—throughs 40.07 Sequestration adjustment—PARHM pass—throughs 40.08 Sequestration adjustment—PARHM (for contractors use only) 41.00 Interim payments—PARHM Tentative settlement (for contractor use only) 42.01 Tentative settlement—PARHM (for contractor use only) 43.00 Balance due provider/program—PARHM (see instructions) 43.01 Balance due provider/program—PARHM (see instructions) 43.01 To BE COMPLETED BY CONTRACTOR  90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 The rate used to calculate the Time Value of Money 92.00  79.00 The rate used to calculate the Time Value of Money		· · · · · · · · · · · · · · · · · · ·	U	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 10 Sequestration adjustment (see instructions) 11			0	39. 75
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   5   5   5   5   5   5   5   5   5		Demonstration payment adjustment amount before sequestration		39. 97
40.00       Subtotal (see instructions)       823       40.00         40.01       Sequestration adjustment (see instructions)       16       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       701       41.00         41.00       Interim payments       701       41.00         41.01       Interim payments-PARHM       701       41.01         42.00       Tentative settlement (for contractors use only)       0       42.00         42.01       Tentative settlement-PARHM (for contractor use only)       42.01         43.00       Balance due provider/program (see instructions)       106       43.00         43.01       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5.15.2       0       44.00         70.00       To BE COMPLETED BY CONTRACTOR       90.00       90.00         90.00       Original outlier amount (see instructions)       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       91.00         92.00       The rate used to calculate the Time Value of Money       92.00				39. 98
40.01       Sequestration adjustment (see instructions)       16       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       40.03         41.00       Interim payments       701       41.00         41.01       Interim payments-PARHM       701       41.00         42.01       Tentative settlement (for contractors use only)       0       42.01         43.00       Bal ance due provider/program (see instructions)       106       43.00         43.01       Bal ance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       44.00         70       BE COMPLETED BY CONTRACTOR       90.00       90.00       90.00       90.00       90.00       91.00         90.00       Outlier reconciliation adjustment amount (see instructions)       91.00       92.00       92.00				
40.02 Demonstration payment adjustment amount after sequestration  40.03 Sequestration adjustment-PARHM pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, only all and the contractor is a contractor of the contractor in the contractor is a contractor of the contractor in the contractor is a contractor of the contractor in the contractor is a contractor of the contractor is a contractor of the contractor in the contractor is a contractor of the contractor in the contractor of the contractor is a contractor of the contra		, , , , , , , , , , , , , , , , , , ,		
41.00 Interim payments  A1.01 Interim payments-PARHM  A2.00 Tentative settlement (for contractors use only)  A2.01 Tentative settlement-PARHM (for contractor use only)  A3.00 Bal ance due provider/program (see instructions)  Bal ance due provider/program-PARHM (see instructions)  A3.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, some settlement (see instructions)  A3.01 Original outlier amount (see instructions)  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  91.00 The rate used to calculate the Time Value of Money				40. 02
41.01   Interim payments-PARHM		i s		40.03
42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Bal ance due provider/program (see instructions)  43.01 Bal ance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{1}{3}\frac{15}{2}\frac{15}{15}\frac{2}{2}\frac{10}{10}\frac{15}{2}\frac{15}{10}\frac{15}{2}\frac{15}{10}\frac{15}{2}\f			701	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  42.01 43.00 43.00 43.01 90.00 91.00 92.00			n	
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{1}{2}\$ 115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  106 43.00 43.01 44.00 43.01				42. 01
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\text{\$115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}\$  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00	43.00	Balance due provider/program (see instructions)	106	43.00
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00			_	43.01
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00	44.00		0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 90.00				
92.00 The rate used to calculate the Time Value of Money 92.00	90.00			90.00
		, , , , , , , , , , , , , , , , , , ,		91.00
73.00   Time value of moley (see first detroits)				
		The factor of money (500 first dott only)	<u> </u>	75.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1311	Peri od:	Worksheet E	
		From 07/01/2022		
	Component CCN: 14-5552	To 06/30/2023	Date/Time Pre	epared:
			11/29/2023 10	): 22 am
	Title XVIII	Skilled Nursing	PPS	
		Facility		
			1. 00	
94.00 Total (sum of lines 91 and 93)				94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200. 00

Health Financial Systems FAIRF ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/29/2023 10: 22 am Provider CCN: 14-1311

					11/29/2023 10	:22 am
		Title	XVIII	Hospi tal	Cost	
		Inpati er	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		2, 409, 067		3, 523, 929	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	<u>'</u>	•			
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3. 02			0		0	3.02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3.05
0.00	Provider to Program					0.00
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3.53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
0. 77	3. 50-3. 98)					0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 409, 067		3, 523, 929	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		_,,		0,000,000	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	•	•		•	
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		411, 909		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		415, 414	6. 02
7.00	Total Medicare program liability (see instructions)		2, 820, 976		3, 108, 515	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th Financial Systems FAIRFIELD MEMORIAL HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider ( In Lieu of Form CMS-2552-10 Peri od: Worksheet E-1
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/29/2023 10: 22 am

Skilled Nursing PPS Provi der CCN: 14-1311

Component CCN: 14-5552

Skilled Nursing Title XVIII

		Title	xVIII S	killed Nursing Facility	PPS	
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		516, 432		701	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		0		0 0	3. 01 3. 02
3. 02					0	3. 02
3. 04			l		l ől	3. 04
3. 05			Ö		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0 0	3.52
3. 53 3. 54					0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
	3. 50-3. 98)		_			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		516, 432		701	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0		0 0	5. 02 5. 03
5.03	Provider to Program					5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		1		106	6. 01
6. 02	SETTLEMENT TO PROGRAM		Ö		0	6. 02
7. 00	Total Medicare program liability (see instructions)		516, 433		807	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		)	1.00	2.00	8. 00
0.00	Name of Contractor			l .	i I	0.00

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL In Lieu					2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1311 Period: \( \)				
			From 07/01/2022 To 06/30/2023		norod.
			To 06/30/2023	Date/Time Pre	
-		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00   Medicare days (see instructions)					2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4. 00	Total inpatient days (see instructions)				4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1311	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Pre	
	Title XVIII	Hospi tal	11/29/2023 10	
	II tie Aviiii	HOSPI LAI	Cost	
PART V - CALCULATION OF REIMBURSEMENT SETT	LEMENT FOR MEDICARE PART A SERVICES - COS	T REIMBURSEMENT	1. 00	

	Title XVIII   Hospital	Cost	
		1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1. 00	Inpatient services	3, 255, 846	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acqui si ti on	0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)	0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)	3, 255, 846	
5.00	Primary payer payments	0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	3, 288, 404	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7. 00	Routine service charges	0	
8. 00	Ancillary service charges	0	8. 00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
12. 00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)	0.000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	
14.00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15.00
14 00	instructions)		14 00
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00
17. 00	instructions)  Cost of physicians' cost is a teaching best tall (see instructions)	0	17. 00
17.00	Cost of physicians' services in a teaching hospital (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT	U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	3, 288, 404	
20. 00	Deductibles (exclude professional component)	421, 799	
21. 00	Excess reasonable cost (from line 16)	0	
22. 00	Subtotal (line 19 minus line 20 and 21)	2, 866, 605	
23. 00	Coi nsurance	21, 138	
24. 00	Subtotal (line 22 minus line 23)	2, 845, 467	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	50, 892	
26. 00	Adjusted reimbursable bad debts (see instructions)	33, 080	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20, 996	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	2, 878, 547	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	o	
29. 98	Recovery of accelerated depreciation.	0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration	0	
30.00	Subtotal (see instructions)	2, 878, 547	30.00
30. 01	Sequestration adjustment (see instructions)	57, 571	
30. 02	Demonstration payment adjustment amount after sequestration	0	30.02
30. 03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2, 409, 067	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	o	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	411, 909	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	17, 812	34.00
	§115. 2		
	·	·	

Health Financial Systems FAIRFIELD MEMORIAL HOSPITAL IN Lieu of Form of CALCULATION OF REIMBURSEMENT SETTLEMENT    Provider CCN: 14-1311	-3 repared: 10: 22 am  99 1.00 0 2.00 0 3.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)  1.00 Resource Utilization Group Payment (RUGS) 2.00 Routine service other pass through costs 3.00 Ancillary service other pass through costs 4.00 Subtotal (sum of lines 1 through 3) COMPUTATION OF NET COST OF COVERED SERVICES 5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.) 6.00 Deductible 7.00 Coinsurance 8.00 Allowable bad debts (see instructions) 9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions) 13.00 Inpatient primary payer payments 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	999 1.00 0 2.00 0 3.00 999 4.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)  1.00 Resource Utilization Group Payment (RUGS)  3.00 Routine service other pass through costs  4.00 Subtotal (sum of lines 1 through 3)  COMPUTATION OF NET COST OF COVERED SERVICES  5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible 7.00 Coinsurance 8.00 Allowable bad debts (see instructions)  8.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  10.00 Adjusted reimbursable bad debts (see instructions)  11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions)  13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 2.00 0 3.00 99 4.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)  1.00 Resource Utilization Group Payment (RUGS)  3.00 Routine service other pass through costs  4.00 Subtotal (sum of lines 1 through 3)  COMPUTATION OF NET COST OF COVERED SERVICES  5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible 7.00 Coinsurance 8.00 Allowable bad debts (see instructions)  8.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  10.00 Adjusted reimbursable bad debts (see instructions)  11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions)  13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 2.00 0 3.00 99 4.00
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)  1.00 Resource Utilization Group Payment (RUGS) 610 2.00 Routine service other pass through costs 3.00 Ancillary service other pass through costs 4.00 Subtotal (sum of lines 1 through 3) 610 COMPUTATION OF NET COST OF COVERED SERVICES  5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible 7.00 Coinsurance 8.00 Allowable bad debts (see instructions) 9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 22.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions) 11.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 2.00 0 3.00 99 4.00
Resource Utilization Group Payment (RUGS)  Routine service other pass through costs  Ancillary service other pass through costs  Subtotal (sum of lines 1 through 3)  COMPUTATION OF NET COST OF COVERED SERVICES  Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  Deductible  Coi nsurance  Allowable bad debts (see instructions)  Reimbursable bad debts for dual eligible beneficiaries (see instructions)  Adjusted reimbursable bad debts (see instructions)  Utilization review  Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions)  11.00  11.00  11.00  11.01  12.00  13.00  13.00  Ther Adjustments (SEE INSTRUCTIONS) (SPECIFY)  14.50  Pioneer ACO demonstration payment adjustment (see instructions)	0 2.00 0 3.00 99 4.00
2.00 Routine service other pass through costs 3.00 Ancillary service other pass through costs 4.00 Subtotal (sum of lines 1 through 3) 610  COMPUTATION OF NET COST OF COVERED SERVICES  5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible 7.00 Coinsurance 8.00 Allowable bad debts (see instructions) 9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 2.00 0 3.00 99 4.00
Ancillary service other pass through costs  4.00 Subtotal (sum of lines 1 through 3) 610  COMPUTATION OF NET COST OF COVERED SERVICES  5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible  7.00 Coinsurance  8.00 Allowable bad debts (see instructions)  9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions)  10.00 Adjusted reimbursable bad debts (see instructions)  11.00 Utilization review  12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions)  14.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 3.00 99 4.00
4.00 Subtotal (sum of lines 1 through 3)  COMPUTATION OF NET COST OF COVERED SERVICES  5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible  7.00 Coinsurance  8.00 Allowable bad debts (see instructions)  9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions)  10.00 Adjusted reimbursable bad debts (see instructions)  11.00 Utilization review  12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions)  13.00 Inpatient primary payer payments  14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  14.50 Pioneer ACO demonstration payment adjustment (see instructions)	99 4.00
COMPUTATION OF NET COST OF COVERED SERVICES  5.00 Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible  7.00 Coinsurance  8.00 Allowable bad debts (see instructions)  9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions)  10.00 Adjusted reimbursable bad debts (see instructions)  11.00 Utilization review  12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)  13.00 Inpatient primary payer payments  14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  14.50 Pioneer ACO demonstration payment adjustment (see instructions)	
Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)  6.00 Deductible Coinsurance Allowable bad debts (see instructions) Reimbursable bad debts for dual eligible beneficiaries (see instructions) Adjusted reimbursable bad debts (see instructions) Utilization review LOO Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions) Linpatient primary payer payments OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) LOO Pioneer ACO demonstration payment adjustment (see instructions)	5 00
6.00 Deductible 7.00 Coinsurance 8.00 Allowable bad debts (see instructions) 9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	1 3.00
7.00 Coinsurance 8.00 Allowable bad debts (see instructions) 9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	
8.00 Allowable bad debts (see instructions) 9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 6.00
9.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	
10.00 Adjusted reimbursable bad debts (see instructions) 11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 8.00
11.00 Utilization review 12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11) (see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 9.00
12.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions) 13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 10.00
13.00 Inpatient primary payer payments 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	
14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 13.00
14.50 Pioneer ACO demonstration payment adjustment (see instructions)	0 14.00
	0 14.50
14.98 Recovery of accelerated depreciation.	0 14. 98
14.99 Demonstration payment adjustment amount before sequestration	0 14. 99
15.00 Subtotal (see instructions 526	
15.01 Sequestration adjustment (see instructions)	
15.02 Demonstration payment adjustment amount after sequestration	0 15.02
15.75 Sequestration for non-claims based amounts (see instructions)	0 15.75
16.00 Interim payments	
17.00 Tentative settlement (for contractor use only)	0 17.00
18.00 Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17) 19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,	1 18.00 0 19.00
§115. 2	

Health Financial Systems FAIRFIELD ME
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provider CCN: 14-1311 Period From 0

oni y)					11/29/2023 10	: 22 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	/ 402 OFF		ما		1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	-6, 402, 055	0	0	0	
3. 00	Notes receivable	0	0	0	0	
4. 00	Accounts receivable	8, 574, 767	Ö	Ö	0	
5.00	Other recei vable	1, 049, 034	0	О	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable		0	0	0	1
7.00	Inventory	59, 837	0	0	0	
8. 00 9. 00	Prepai d expenses	149, 839	0	0	0	
10.00	Other current assets Due from other funds	0		0	0	
11. 00	Total current assets (sum of lines 1-10)	-964, 679		Ö	0	
	FIXED ASSETS	1977911		-1		1
12.00	Land	25, 000	0	0	0	12.00
13.00	Land improvements	270, 207		0	0	
14.00	Accumulated depreciation	-86, 350		0	0	
15.00	Buildings	2, 382, 251	0	0	0	
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-1, 374, 445	0	0	0	
18.00	Accumulated depreciation		0	0	0	
19. 00	Fi xed equipment	-117, 407	0	Ö	0	
20.00	Accumulated depreciation	-69, 407	Ö	o	0	
21.00	Automobiles and trucks	0	0	o	0	21.00
22.00	Accumulated depreciation	0	0	O	0	22.00
23. 00	Major movable equipment	5, 339, 183		0	0	1
24. 00	Accumulated depreciation	-1, 157, 185		0	0	
25.00	Minor equipment depreciable	0	0	0	0	
26. 00 27. 00	Accumulated depreciation	-20	0	0	0	
28.00	HIT designated Assets Accumulated depreciation		0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	124, 853	-	0	0	
30.00	Total fixed assets (sum of lines 12-29)	5, 336, 680		ő	0	
	OTHER ASSETS			-		
31.00	Investments	-1, 109, 019		0	0	
32.00	Deposits on Leases	0	0	0	0	
33.00	Due from owners/officers	0	0	0	0	
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	-1, 109, 019	0	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	3, 262, 982		Ö	0	
	CURRENT LIABILITIES			-1		1
37.00	Accounts payable	499, 421	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	132, 999	0	0	0	
39. 00	Payroll taxes payable	0	0	0	0	
40.00	Notes and loans payable (short term)	-213, 827	0	0	0	
41.00	Deferred income Accelerated payments	0	0	U	0	41.00
42. 00 43. 00	Due to other funds	0	0	0	0	
44. 00	Other current liabilities	-1	0	Ö	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	418, 592	Ö	Ö		
	LONG TERM LIABILITIES					
46.00	Mortgage payable	-374, 653	0	0	0	
47.00	Notes payable	3, 333, 561		0	0	
48.00	Unsecured Loans	0	0	0	0	
49.00	Other long term liabilities	2 050 000	0	0	0	•
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	2, 958, 908 3, 377, 500		0	0	
31.00	CAPITAL ACCOUNTS	3,377,300	J			31.00
52. 00	General fund balance	-114, 518				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			o		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59. 00	Total fund balances (sum of lines 52 thru 58)	-114, 518	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	3, 262, 982		ől	0	
	59)			آ	_	
		•	. '	'		

FAIRFIELD MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared: Provider CCN: 14-1311

					10 06/30/2023	11/29/2023 10	
		General	Fund	Speci al	Purpose Fund	Endowment	
						Fund	
4 00	To a trade constant and the standard and	1. 00	2.00	3. 00	4. 00	5. 00	4 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		ı -114, 519		0		1.00
3. 00	Total (sum of line 1 and line 2)		-114, 519 -114, 518		0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	-114, 510		0	0	1
5. 00	(Specify)	o o			0	Ö	
6. 00		o			0	Ō	
7.00		o			0	0	7.00
8.00		0			0	0	8. 00
9.00		0			0	0	
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-114, 518		0		11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0	0 0	
14.00		0			0	0	1
15. 00		0			0	0	1
16. 00		o o			0	0	1
17. 00		o			0	0	
18.00	Total deductions (sum of lines 12-17)		0		0		18. 00
19. 00	Fund balance at end of period per balance		-114, 518		0		19. 00
	sheet (line 11 minus line 18)			L			
		Endowment Fund	PI ant	Fund			
		Fullu			_		
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5. 00 6. 00			0				5. 00 6. 00
7. 00			0				7.00
8. 00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	o			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15. 00 16. 00
16. 00 17. 00			0				17.00
18.00	Total deductions (sum of lines 12-17)	ام	0		0		18.00
19. 00	Fund balance at end of period per balance	ol			0		19.00
	sheet (line 11 minus line 18)						

Health Financial Systems FA STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1311

			To	06/30/2023	Date/Time Pre 11/29/2023 10	
	Cost Center Description	I npati er	+	Outpati ent	Total	. 22 aiii
	oust defited beset per on	1.00		2.00	3. 00	
	PART I - PATIENT REVENUES			2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	3, 675	745		3, 675, 745	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY	1, 515	819		1, 515, 819	7.00
8. 00	NURSING FACILITY	, , , , , ,			,	8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 191	564		5, 191, 564	10.00
	Intensive Care Type Inpatient Hospital Services			'		
11.00	INTENSIVE CARE UNIT	170	700		170, 700	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	s 170	700		170, 700	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5, 362	264		5, 362, 264	17.00
18.00	Ancillary services	12, 744	768	132, 095, 389	144, 840, 157	18.00
19.00	Outpati ent servi ces		0	0	0	19.00
20.00	RURAL HEALTH CLINIC		0	5, 178, 758	5, 178, 758	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY			540, 033	540, 033	22.00
23.00	AMBULANCE SERVICES		0	0	0	23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27. 00	OTHER (SPECIFY)		0	0	0	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to We	kst. 18, 107,	032	137, 814, 180	155, 921, 212	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			52, 135, 696		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00	T-+-1		0	0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38.00
39.00			0			39.00
40.00			0			40.00
41.00	Total deductions (sum of lines 37-41)		U			41. 00 42. 00
42. 00 43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfor		52 12E 404		42. 00 43. 00
43.00	to Wkst. G-3, line 4)	a1151 E1		52, 135, 696		43.00
	10 WKSt. 0-3, TITIC 4)	1	I	l		

Heal th	Financial Systems FAIRFIELD MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 14-1311	Peri od:	Worksheet G-3	
	<u> </u>		From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 10	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	19. 28)		155, 921, 212	1, 00
2. 00	Less contractual allowances and discounts on patients' accour			105, 086, 624	2.00
3. 00	Net patient revenues (line 1 minus line 2)			50, 834, 588	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		52, 135, 696	
5. 00	Net income from service to patients (line 3 minus line 4)	,		-1, 301, 108	5. 00
	OTHER I NCOME			, ,	
6.00	Contributions, donations, bequests, etc			304, 586	6.00
7.00	Income from investments			22, 514	7. 00
8.00	Revenues from telephone and other miscellaneous communication	ı servi ces		0	8. 00
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			-7, 145	
12.00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	13.00
14. 00				242, 701	
	Revenue from rental of living quarters			-	15.00
	Revenue from sale of medical and surgical supplies to other t	han patients		0	
	Revenue from sale of drugs to other than patients				
	Revenue from sale of medical records and abstracts			12, 240	
	Tuition (fees, sale of textbooks, uniforms, etc.)				19.00
20. 00				0	
21. 00	1				21.00
22. 00	Rental of hospital space			436, 999	
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER OPERATING INCOME			174, 110	
24. 50				0	
	Total other income (sum of lines 6-24)			1, 186, 589	
	Total (line 5 plus line 25)			-114, 519	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			114 510	
29.00	Net income (or loss) for the period (line 26 minus line 28)		l	-114, 519	∠9.00

Heal th	Financial Systems	ı	FAIRFIELD MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	ALLOCATION - HHA GENERAL SERVICE			Provi der C	CN: 14-1311	Period: From 07/01/2022	Worksheet H-1 Part I	
				HHA CCN:	14-7612	To 06/30/2023		pared:
						Home Health	PPS	: ZZ alli
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	
	T	0	1. 00	2.00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &	0	0		I		0	1.00
	Fixtures						_	
2. 00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	0	
4. 00 5. 00	Transportation Administrative and General	182, 494	0	0	•	0 0	182, 494	4. 00 5. 00
	HHA REIMBURSABLE SERVICES		-1					
6. 00 7. 00	Skilled Nursing Care Physical Therapy	255, 174 45, 780	0	0	•	0 0	255, 174 45, 780	
8.00	Occupational Therapy	15, 570	Ö	0	•	0 0	15, 570	8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	1, 332	0	0		0 0	1, 332 0	1
11. 00	Home Heal th Ai de	0	Ö	0		0 0	Ö	1
12. 00 13. 00	Supplies (see instructions)	25, 612 0	0	0		0 0	25, 612 0	12.00 13.00
14. 00	Drugs DME	0	0	0		0 0	0	1
15 00	HHA NONREI MBURSABLE SERVI CES		ما	0	I			15 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	l .	0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0	1		0	
20.00	Day Care Program	o o	Ö	0		0 0	0	20. 00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
23. 00	All Others (specify)	0	ő	0		0 0	0	
23. 50	Tel emedicine	0	O	0		0 0	0	
24.00	Total (sum of lines 1-23)	525, 962 Admi ni strati v	Total (cols.	0		U U	525, 962	24.00
		e & General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	5.00	0.00					
1. 00	Capital Related - Bldg. & Fixtures							1.00
2. 00	Capital Related - Movable							2. 00
3. 00	Equipment Plant Operation & Maintenance							3.00
4. 00	Transportation							4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	182, 494						5.00
6. 00	Skilled Nursing Care	135, 581	390, 755					6. 00
7.00	Physi cal Therapy	24, 324	70, 104					7.00
8. 00 9. 00	Occupational Therapy Speech Pathology	8, 273 708	23, 843 2, 040					8. 00 9. 00
10.00	Medical Social Services	0	0					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	0 13, 608	0 39, 220					11. 00 12. 00
13. 00		0	0					13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	0					16.00
17. 00 18. 00		0	0					17. 00 18. 00
19.00	II .	0	0					19.00
20. 00 21. 00	3	0	0					20. 00 21. 00
22.00	Homemaker Service	0	О					22. 00
	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		525, 962					24. 00

llool +b	Financial Cystems	r	ALDELELD MEMO			la li o	u of Form CMC (	2552 10
	Financial Systems LLOCATION - HHA STATISTICAL BAS		FAIRFIELD MEMO	Provider C	∩N: 1/ 1211	IN LIE Period:	u of Form CMS-2 Worksheet H-1	
C031 F	ELECCATION - IIIA STATISTICAL BA	51 5		HHA CCN:		From 07/01/2022 To 06/30/2023	Part II	pared:
						Home Health	PPS	. ZZ alli
						Agency I		
		Capi tal Rel	ated Costs					
		BI dgs &	Movabl e	PI ant		Reconciliatio		
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	VALUE)	(SQUARE FEET)	4.00	FA 00	F 00	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00	Capital Related - Bldg. &	0				0	I	1.00
1.00	Fixtures	١				0		1.00
2.00	Capital Related - Movable		0			0		2.00
2.00	Equi pment		0					2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportation (see		0	0		ol		4.00
00	instructions)		· ·					
5.00	Administrative and General	o	0	0		-182, 494	343, 468	5.00
	HHA REIMBURSABLE SERVICES			•	•	<u> </u>	·	1
6.00	Skilled Nursing Care	0	0	0		0 0	255, 174	6.00
7.00	Physi cal Therapy	o	0	0		0 0	45, 780	7.00
8.00	Occupational Therapy	0	0	0		0	15, 570	8.00
9.00	Speech Pathology	0	0	0		0	1, 332	9.00
10.00	Medical Social Services	0	0	0		0	0	10.00
11. 00	Home Health Aide	0	0	0		0	0	11.00
12.00	Supplies (see instructions)	0	0	0		0	25, 612	12.00
13.00	Drugs	0	0			0		
14. 00	DME	0	0	0		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES							1
15. 00	Home Dialysis Aide Services	0	0			0		
16. 00	Respiratory Therapy	0	0	0		0		
17. 00	Private Duty Nursing	0	0	0		0	0	1
18.00	Clinic	0	0	0		0	0	
19.00	Health Promotion Activities	0	0	0		0	0	19.00
20.00	Day Care Program	0	0	0		0	0	0.00
21. 00	Home Delivered Meals Program	0	0	0		0	0	21.00
22. 00 23. 00	Homemaker Service All Others (specify)		0					22. 00 23. 00
23. 50	Telemedicine		0	0		0 0	0	
24. 00	Total (sum of lines 1-23)		0			0 -182, 494		
25. 00	Cost To Be Allocated (per		0			- 102, 494	182, 494	
25.00	Worksheet H-1, Part I)		0				102, 474	25.00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	0	0. 531328	26. 00

Home Health

Agency I CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** ADMI NI STRATI V HHA Trial Subtotal Cost Center Description Bal ance (1) **BENEFITS** E & GENERAL DEPARTMENT 0 1. 00 2.00 4.00 4A 5. 00 1.00 Administrative and General 25. 757 66, 014 9.810 1.00 32, 492 7,765 2.00 Skilled Nursing Care 390, 755 61,608 452, 363 67, 223 2.00 Physical Therapy 70, 104 0 11,053 81, 157 3.00 0 12,060 3.00 Occupational Therapy 0 27, 602 4.00 23.843 0 3.759 4, 102 4.00 0 5.00 2,040 322 Speech Pathology C 2, 362 351 5.00 6.00 Medical Social Services 0 C 0 6.00 7.00 Home Heal th Aide 0 0 7.00 Supplies (see instructions) 39, 220 0 0 0 0 5. 828 8 00 39 220 8 00 9.00 Drugs 0 C 0 9.00 10.00 DMF 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 11.00 Respiratory Therapy 0 0 0 0 12 00 12 00 13.00 Private Duty Nursing 0 0 0 13.00 14.00 0 0 0 14.00 Clinic 0 Health Promotion Activities 0 15.00 15.00 0 0 Day Care Program 0 16.00 Ω 16.00 17.00 Home Delivered Meals Program 0 0 C 0 0 17.00 0 18.00 Homemaker Service 0 0 0 18.00 All Others (specify) 0 0 19 00 0 19 00 C 0 19.50 Tel emedi ci ne 0 0 19.50 Total (sum of lines 1-19) (2) 525, 962 32, 492 7, 765 102, 499 668, 718 99, 374 20.00 20.00 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A Cost Center Description REPAI RS PLANT LINEN SERVICE 11.00 10.00 8.00 9.00 6.00 7.00 1.00 Administrative and General 16, 343 15, 236 20, 460 0 1.00 2.00 Skilled Nursing Care 0 0 2.00 Physical Therapy 0 0 0 0 0 3.00 0 3.00 0 0 0 4.00 Occupational Therapy 0 4 00 Speech Pathology 5.00 0 5.00 6.00 Medical Social Services 0 0 0 6.00 0000000000 0 0 0 0 Home Health Aide 7.00 0 7.00 0 0 8.00 Supplies (see instructions) Ω 8.00 9.00 0 0 0 0 0 0 0 0 Drugs 9.00 10.00 DME 0 10.00 0 0 11.00 11.00 Home Dialysis Aide Services 0 0 12.00 Respiratory Therapy C 0 12.00 13.00 Private Duty Nursing 13.00 14.00 0 0 Clinic 14.00 15.00 Health Promotion Activities 0 C 0 15.00 Day Care Program 0 0 0 0 16.00 16.00 0 17.00 Home Delivered Meals Program 0 0 0 17.00 18.00 Homemaker Service 0 0 0 0 18.00 19.00 All Others (specify) 0 0 C 0 19.00 19.50 19.50 Tel emedi ci ne 0 Total (sum of lines 1-19) (2) 16, 343 15, 236 20, 460 20.00 20.00 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

HHA CCN:

			TITA CCN.	14-7012	10 00/30/2023	11/29/2023 10	
					Home Health	PPS	
Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Agency I SOCI AL SERVI CE	Subtotal	
	13. 00	14. 00	15. 00	16. 00	17. 00	24. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	40, 955 0 0 0 0 0 0 0 0 0 0 0 0 0	607			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	169, 425 519, 586 93, 217 31, 704 2, 713 0 45, 048 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
1.00 Administrative and General	25. 00	26. 00 169, 425	27. 00	28. 00			1.00
2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service	000000000000000000000000000000000000000	519, 586 93, 217 31, 704 2, 713 0 45, 048 0 0 0 0 0	127, 163 22, 814 7, 759 664 0 11, 025 0 0 0 0 0 0 0 0 0 0 0	116, 03 39, 46 3, 37 56, 07	1 3 7 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 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 0	0 0 861, 693	0 0 169, 425 0. 244739		0 0 3 3		19. 00 19. 50 20. 00 21. 00

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

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS T BASIS		Peri od: Worksheet H-2 From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:
	11	11/29/2023 10: 22 am

							11/29/2023 10	. ZZ alli
						Home Health Agency I	PPS	
		CAPI TAL REL	ATED COSTS			Agency I		
	Cost Contor Doscription	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Doconci Li ati o	ADMI NI STRATI V	MAINTENANCE O	
	Cost Center Description	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	REPAI RS	
		(020/2 1221)	(040/1112 / 221)	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
				(GROSS				
		1. 00	2. 00	4. 00	5A	5. 00	6. 00	
1. 00	Administrative and General	1, 920	1, 920		O. C.		1, 920	1.00
2.00	Skilled Nursing Care	0	0	255, 174	1	,	0	2.00
3.00	Physical Therapy	0	0	45, 780			0	3.00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	15, 570 1, 332		2.,002	0	4. 00 5. 00
6. 00	Medical Social Services	0	0	1, 332		,	l o	6.00
7. 00	Home Health Aide	0	0	o	C	1	0	7. 00
8.00	Supplies (see instructions)	0	0	0	C	39, 220	0	8.00
9. 00 10. 00	Drugs DME	0	0	0			0	9. 00 10. 00
11. 00	Home Dialysis Aide Services		0				0	11.00
12.00	Respiratory Therapy	0	0	0	d	0	0	
13.00	Private Duty Nursing	0	0	0	C	0	0	
14. 00 15. 00	Clinic Health Promotion Activities	0	0	0	C	0	0	14. 00 15. 00
16. 00	Day Care Program	0	0				0	
17. 00	Home Delivered Meals Program	0	0	O	d	0	O	17. 00
18. 00	Homemaker Service	0	0	0	C	0	0	18.00
19.00	All Others (specify)	0	0	0		0	0	19.00
20. 00	Telemedicine Total (sum of lines 1-19)	1, 920	1, 920	424, 537		668, 718	0 1, 920	19. 50 20. 00
21. 00	Total cost to be allocated	32, 492	7, 765			99, 374		1
22. 00	Unit cost multiplier	16. 922917	4. 044271			0. 148604		22.00
	Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	NURSI NG	
		(SQUARE FEET)	(POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(FIES SERVED)	ADMINISTRATIO N	
		(020/2 1221)	LAUNDRY)		02.1125)		(DI RECT NURS.	
		7.00	0.00	0.00	10.00	11 00	HRS. )	
1. 00	Administrative and General	7. 00	8. 00	9. 00 1, 920	10.00	11. 00	13. 00 13, 386	1.00
2. 00	Skilled Nursing Care	0	0	0,720	d	1	0	2.00
3.00	Physical Therapy	0	0	0	C	0	0	3. 00
4. 00	Occupational Therapy	0	0	0		0	0	4.00
5. 00 6. 00	Speech Pathology Medical Social Services	0	0	0			0	5. 00 6. 00
7. 00	Home Heal th Ai de	0	0	Ö			l o	7. 00
8.00	Supplies (see instructions)	0	0	0	c	0	0	8. 00
9.00	Drugs	0	0	0		0	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0			0	10. 00 11. 00
12. 00	Respiratory Therapy	0	0				0	12.00
13.00	Private Duty Nursing	0	0	0	C	0	0	
14.00	Clinic	0	0	0	C	0	0	
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0		-	0	
17. 00	Home Delivered Meals Program		0	0		,	0	1
18. 00	Homemaker Service	0	0	0	d	0	0	1
19.00	All Others (specify)	0	0	0	C	0	0	19.00
19. 50	Telemedicine Total (sum of lines 1-19)	1, 920	0	0 1, 920		0	0 13, 386	19.50
21.00	Total cost to be allocated	15, 236	0	20, 460				20.00
22. 00	1	7. 935417	0. 000000			0.000000		

Health Financial Systems	FAIRFIELD MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS		Peri od: Worksheet H-2 From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared: 11/29/2023 10:22 am

						Home Health	PPS	
						Agency I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL			
		SERVICES &	(COSTED	RECORDS &	SERVI CE			
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)			
		(COSTED		(TIME SPENT)				
		REQUIS.)						
		14. 00	15. 00	16. 00	17. 00			
1.00	Administrative and General	25, 612	0	0	(			1.00
2.00	Skilled Nursing Care	0	0	0	(			2.00
3.00	Physi cal Therapy	0	0	0	(			3.00
4.00	Occupational Therapy	0	0	0	(			4.00
5.00	Speech Pathology	0	0	0	(			5.00
6. 00	Medical Social Services	0	0	0	(	O		6.00
7.00	Home Health Aide	0	0	0	(			7.00
8.00	Supplies (see instructions)	0	0	0	(			8.00
9. 00	Drugs	0	0	0	(	D		9. 00
10.00	DME	0	0	0	(	D		10.00
11.00	Home Dialysis Aide Services	0	0	0	(			11.00
12.00	Respiratory Therapy	0	0	0	(			12.00
13.00	Private Duty Nursing	0	0	0	(			13.00
14.00	Clinic	0	0	0	(	D		14.00
15.00	Health Promotion Activities	0	0	0	(	D		15.00
16.00	Day Care Program	0	0	0	(			16.00
17.00	Home Delivered Meals Program	0	0	0	(			17.00
18.00	Homemaker Service	0	0	0	(			18.00
19.00	All Others (specify)	0	0	0				19.00
19. 50	Tel emedi ci ne	o	0	0	(			19. 50
20.00	Total (sum of lines 1-19)	25, 612	0	0	(			20.00
21.00	Total cost to be allocated	607	0	0				21.00
22. 00	Unit cost multiplier	0. 023700	0. 000000	0. 000000	0. 000000			22.00
	•	. '			•	*		•

Hool +h	Financial Systems		FAIRFIELD MEMOR	NAL HOCDITAL		In Lie	u of Form CMS 1	DEE2 10
	Financial Systems FIONMENT OF PATIENT SERVICE COST		FAIRFIELD WEWOR	Provi der CO	^N: 1 <i>4</i> _1311	Peri od:	u of Form CMS-2 Worksheet H-3	
711 1 0101	TOWNENT OF TATLENT SERVICE GGS	13		HHA CCN:	14-7612	From 07/01/2022 To 06/30/2023	Part I Date/Time Pre	pared:
				Title	XVIII	Home Health Agency I	11/29/2023 10 PPS	: 22 alli
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷	
			Part I)	Part II)			col . 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation							
1. 00	Skilled Nursing Care	2.00			646, 7			1. 00
2.00	Physi cal Therapy	3.00		0				
3.00	Occupational Therapy	4.00		0	,			
4.00	Speech Pathology	5.00		0	3, 3			
5.00	Medical Social Services	6.00	1			0		
6.00	Home Health Aide	7.00	0			0	0.00	6. 00
7.00	Total (sum of lines 1-6)		805, 620	0	805, 62	20 2, 771		7. 00
					Program Visi	ts		
					P.	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	, , , , , , , , , , , , , , , , , , ,		, , , ,		to	Deducti bl es		
					Deducti bl es			
		0	1.00	2.00	Coi nsurance		F 00	
	Limitation Cost Computation		1. 00	2. 00	3. 00	4. 00	5. 00	
8. 00	Skilled Nursing Care		99914	0	1, 0	17		8. 00
9. 00	Physical Therapy		99914	0		32		9.00
		•	99914	0		54 54		
10. 00 11. 00	Occupational Therapy Speech Pathology		99914	0		24		10. 00 11. 00
12. 00	Medical Social Services		99914	0		0		12.00
13. 00	Home Health Aide		99914	0	•	1		13.00
14. 00	•		77714	0	1, 8:	20		14.00
14.00	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	14.00
	cost center bescription	H-2 Part I,	Costs (from	Ancillary	Costs (cols			
		col. 28, line		Costs (from	1 + 2)	Records)	÷ col. 4)	
		col. 28, line	Wkst. H-2, Part I) 1.00		,		÷ col . 4)	
	Supplies and Drugs Cost Comput	0	Part I)	Costs (from Part II)	1 + 2)	Records)	ŕ	
	Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs	0	Part I) 1.00	Costs (from Part II) 2.00	1 + 2) 3.00	Records)	5. 00	
	Cost of Medical Supplies	0 ations 8.00 9.00	Part I) 1.00	Costs (from Part II) 2.00 0	1 + 2) 3.00 56,0°	Records) 4. 00 73 126, 787	5. 00	
	Cost of Medical Supplies	0 ations 8.00 9.00	Part I) 1.00 56,073 0 Program Visits	Costs (from Part II) 2.00	1 + 2) 3.00 56,0	Records)  4. 00  73  126, 787  0  0	5. 00	
	Cost of Medical Supplies Cost of Drugs	0 ations 8.00 9.00	Part I) 1.00  56,073 0  Program Visits Part	Costs (from Part II) 2.00  0 0 t B	1 + 2) 3.00 56,0 Cost of Services	Records)  4.00  73  126,787  0  0  Part B	5. 00 0. 442261 0. 000000	
	Cost of Medical Supplies	0 ations 8.00 9.00	Part I) 1.00  56,073 0  Program Visits  Part Not Subject	Costs (from Part II) 2.00  0 0 t B Subject to	1 + 2) 3.00 56,0°	Records)  4.00  73 126,787 0 0 Part B Not Subject	5. 00 0. 442261 0. 0000000 Subj ect to	
	Cost of Medical Supplies Cost of Drugs	0 ations 8.00 9.00	Part I) 1.00 56,073 0 Program Visits Part Not Subject to	Costs (from Part II) 2.00  0 0 t B Subject to Deductibles &	1 + 2) 3.00 56,0 Cost of Services	Records)  4.00  73 126,787 0 0  Part B Not Subject to	5.00 0.442261 0.000000 Subject to Deductibles &	
	Cost of Medical Supplies Cost of Drugs	0 ations 8.00 9.00	Part I) 1.00 56,073 0 Program Visits Part Not Subject to Deductibles &	Costs (from Part II) 2.00  0 0 t B Subject to Deductibles &	1 + 2) 3.00 56,0 Cost of Services	Records)  4.00  73 126,787 0 0  Part B  Not Subject to Deductibles &	5.00 0.442261 0.000000 Subject to Deductibles &	
	Cost of Medical Supplies Cost of Drugs	0 ations 8.00 9.00	Part I) 1.00 56,073 0 Program Visits Part Not Subject to	Costs (from Part II) 2.00  0 0 t B Subject to Deductibles &	1 + 2) 3.00 56,0 Cost of Services	Records)  4.00  73 126,787 0 0  Part B Not Subject to	5.00 0.442261 0.000000 Subject to Deductibles &	
	Cost of Medical Supplies Cost of Drugs	0 ations 8.00 9.00 Part A	Part I) 1.00  56,073 0 Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance 8.00	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73 126,787 0 0  Part B  Not Subject to Deducti bles & Coi nsurance 10.00	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance  11.00	
	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER	0 ations 8.00 9.00 Part A	Part I) 1.00  56,073 0 Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance 8.00	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73 126,787 0 0  Part B  Not Subject to Deducti bles & Coi nsurance 10.00	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance  11.00	
	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION	0 ations 8.00 9.00 Part A	Part I) 1.00  56,073 0  Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00  PROGRAM COST, A	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance  8.00 AGGREGATE OF TH	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73 126,787 0 0  Part B  Not Subject to Deducti bles & Coi nsurance 10.00	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance  11.00	
16.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Part I) 1.00  56,073 0  Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00  PROGRAM COST, A	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TH	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73 126,787 0 0  Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, (	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance 11.00  DR BENEFICIARY	16.00
1. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Part I) 1.00  56,073 0 Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF Th	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73 126, 787 0 0  Part B  Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, 0	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance  11.00  R BENEFICIARY	1. 00
1. 00 2. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Part I) 1.00  56,073 0 Program Visits Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TH	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance 11.00  R BENEFICIARY	1. 00
1. 00 2. 00 3. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Part I) 1.00  56,073 0 Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TH	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance 11.00  R BENEFICIARY	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Part I) 1.00  56,073 0 Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Costs (from Part II) 2.00  t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TH	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance 11.00  R BENEFICIARY	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Part I)  1.00  56,073 0 Program Visits  Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A  1,017 532 264 24 0 1	Costs (from Part II) 2.00  0 0 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TH	1 + 2) 3.00 56,00 Cost of Services Part A	Records)  4.00  73	5.00  0.442261 0.000000  Subject to Deductibles & Coinsurance 11.00  OR BENEFICIARY	1. 00 2. 00 3. 00 4. 00 5. 00

APPUR	FIONMENT OF PATIENT SERVICE COS	TC		Provider Co	^NI: 1/ 1011	Peri od:	Worksheet H-3	2552-10
	TIONMENT OF PATTENT SERVICE COS	15		HHA CCN:	14-7612	From 07/01/2022 To 06/30/2023	Part I	pared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description			'				
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Limitation Cost Computation	ı						
8.00	Skilled Nursing Care							8. 00 9. 00
9.00	Physical Therapy	•						
10. 00 11. 00	Occupational Therapy Speech Pathology							10.00
12. 00	Medical Social Services							12.00
12.00	Home Health Aide							13.00
	Total (sum of lines 8-13)							14.00
14.00	Total (suil of Titles 6-13)	Prog	ll ram Covered Cha	raec	Cost of			14.00
		Frog	alli covereu cha	ii ges	Servi ces			
					Jei vi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Comput							
15.00		0	65, 506	0		0 28, 971	0	
16.00	Cost of Drugs		0	0		0	0	16.00
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10)						1
	DART I COMPUTATION OF LEGGER	12. 00	DDOODAM OOCT A	00050475 05 71	IE DDOODAM I	MITATION COST	AD DENIEL OLADY	
	PART I - COMPUTATION OF LESSER	12. 00	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	COST LIMITATION	12. 00	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
1 00	COST LIMITATION Cost Per Visit Computation	12.00 OF AGGREGATE		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	1 00
1.00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	12. 00 OF AGGREGATE 389, 887		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	
2.00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	12. 00 OF AGGREGATE 389, 887 84, 216		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2.00
2. 00 3. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy	12. 00 OF AGGREGATE 389, 887 84, 216 32, 055		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2. 00 3. 00
2. 00 3. 00 4. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology	12. 00 OF AGGREGATE 389, 887 84, 216 32, 055 3, 117		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2.00 3.00 4.00
2. 00 3. 00 4. 00 5. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology  Medical Social Services	12. 00 OF AGGREGATE 389, 887 84, 216 32, 055 3, 117		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology  Medical Social Services  Home Health Aide	12. 00 OF AGGREGATE 389, 887 84, 216 32, 055 3, 117 0		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology  Medical Social Services  Home Health Aide  Total (sum of lines 1-6)	12. 00 OF AGGREGATE 389, 887 84, 216 32, 055 3, 117		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology  Medical Social Services  Home Health Aide	12. 00 OF AGGREGATE  389, 887 84, 216 32, 055 3, 117 0 509, 275		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology  Medical Social Services  Home Health Aide  Total (sum of lines 1-6)	12. 00 OF AGGREGATE 389, 887 84, 216 32, 055 3, 117 0		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation	12. 00 OF AGGREGATE  389, 887 84, 216 32, 055 3, 117 0 509, 275		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy Occupational Therapy Speech Pathology  Medical Social Services Home Health Aide  Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care	12. 00 OF AGGREGATE  389, 887 84, 216 32, 055 3, 117 0 509, 275		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology  Medical Social Services  Home Health Aide  Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care  Physical Therapy	12. 00 OF AGGREGATE  389, 887 84, 216 32, 055 3, 117 0 509, 275		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	PR BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care Physical Therapy Occupational Therapy	12. 00 OF AGGREGATE  389, 887 84, 216 32, 055 3, 117 0 509, 275		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy Speech Pathology  Medical Social Services  Home Health Aide  Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care  Physical Therapy Occupational Therapy Speech Pathology	12. 00 OF AGGREGATE  389, 887 84, 216 32, 055 3, 117 0 509, 275		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care Physical Therapy Occupational Therapy	12. 00 OF AGGREGATE  389, 887 84, 216 32, 055 3, 117 0 509, 275		AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00

Heal th	Financial Systems	1	FAIRFIELD MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C	CN: 14-1311	Peri od:	Worksheet H-3	
				HHA CCN:	14-7612	From 07/01/2022 To 06/30/2023		
							11/29/2023 10	<u>:22 am</u>
						Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line	_	provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	ITAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 397972	C		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 455493	C		Ocol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 611316	C		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 292220	C	)	0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 356700	c	)	0 col. 2, line 1	6. 00	5.00

	Financial Systems FAIRFIELD MEMO ATION OF HHA REIMBURSEMENT SETTLEMENT	ORIAL HOSPITAL Provider C	CN: 14-1311	Period:	eu of Form CMS-2 Worksheet H-4	
_00L	NTON ST. THAT RET INDUITE SETTE EMENT	HHA CCN:	14-7612	From 07/01/2022 To 06/30/2023	Part I-II Date/Time Pre	pare
		Title	XVIII	Home Health	11/29/2023 10 PPS	): 22
				Agency I	⊥ rt B	
			Part A	Not Subject	Subject to	
				to Deductibles &	Deductibles & Coinsurance	
			1.00	Coi nsurance 2. 00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR (	CUSTOMARY CHARGE	S			
	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0		١,
0 0	Total charges			0 0	1	
	Customary Charges				,	1
0	Amount actually collected from patients liable for paymen	t for services		0 (	0	] 3
.	on a charge basis (from your records)	£				١,
0	Amount that would have been realized from patients liable for services on a charge basis had such payment been made with 42 CFR §413.13(b)			0	0	4
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	l .	
0	Total customary charges (see instructions)			0	1	
0	Excess of total customary charges over total reasonable conly if line 6 exceeds line 1)	ost (complete		0	0	7
00	Excess of reasonable cost over customary charges (complete	e only if line		0 (	0	8
0	1 exceeds line 6) Primary payer amounts			0	0	9
				Part A	Part B	
				Servi ces 1.00	Servi ces 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
00	Total reasonable cost (see instructions)			(		
00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				1,	
	Total PPS Reimbursement - LUPA Episodes				43, 038 6, 194	
00	Total PPS Reimbursement - PEP Epi sodes					
00	Total PPS Outlier Reimbursement - Full Episodes with Outl	i ers			9, 065	
00	Total PPS Outlier Reimbursement - PEP Episodes					
00	Total Other Payments			(	0	17
00	DME Payments			(	0	18
	Oxygen Payments			(	0	
	Prosthetic and Orthotic Payments				1	
	Part B deductibles billed to Medicare patients (exclude of	oi nsurance)			0	
	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)					
	Subtotal (line 22 minus line 23)				1	
00	Coinsurance billed to program patients (from your records	)			0	1
	Net cost (line 24 minus line 25)	,			1	
	Allowable bad debts (from your records)				0	1
	Adjusted reimbursable bad debts (see instructions)				0	
	Allowable bad debts for dual eligible (see instructions)				0	
1	Total costs - current cost reporting period (see instruct	i ons)		(	1	
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	11			1	
1	Pioneer ACO demonstration payment adjustment (see instruc				1	
1	Demonstration payment adjustment amount before sequestrat Subtotal (see instructions)	1 011			1	
00 01	Sequestration adjustment (see instructions)					
02	Demonstration payment adjustment amount after sequestration	on			1	1
75	Sequestration adjustment for non-claims based amounts (se					1
	Interim payments (see instructions)				1	
	Tentative settlement (for contractor use only)					1
00				1	1	
	Balance due provider/program (line 31 minus lines 31.01,	31.02, 31.75, 32	2, and 33)	(	) 1	34

Health Financial Systems FAIRFIELD MEMORIANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 FAIRFIELD MEMORIAL HOSPITAL

Peri od: | Worksheet ... | From 07/01/2022 | Date/Ti me Prepared: | 11/29/2023 | 10: 22 am | PPS Provi der CCN: 14-1311 TO PROGRAM BENEFICIARIES HHA CCN: 14-7612

					11/29/2023 10:	: 22 am
				Home Health	PPS	
				Agency I		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			0	409, 571	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		•	<u>'</u>	•	
3. 01				0	0	3. 01
3. 02				0	l ol	3. 02
3. 03				0	o	3. 03
3. 04				0	0	3. 04
3. 05				0	l ől	3. 05
0.00	Provider to Program			<u> </u>		0.00
3. 50	11 ovi doi - to 11 ogi diii			0	0	3. 50
3. 51				0	l ől	3. 51
3. 52				0		3. 52
3. 53				0		3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
3. 99	3. 50-3. 98)			٥	١	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)			0	409, 571	4. 00
4.00	(transfer to Wkst. H-4, Part II, column as appropriate,			٥	409, 371	4.00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	Program to Provider			0	0	5. 01
5. 01				0		5. 01
5. 02				0		5. 02
5.05	Provider to Program			<u>U</u>		5.03
5. 50	FI OVI GET LO PI OGLATII			0	0	5. 50
5. 51			l .	0		5. 50
				-		
5. 52	Cultural (			0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	ا	5. 99
, 00	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)					, 01
6. 01	SETTLEMENT TO PROVIDER			0	1	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	409, 572	7.00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		)	1. 00	2.00	8. 00
ø. UU	INAILE OF COILLEACTOR				1	8.00

Heal th	Financial Systems	FAIRFIELD MEMOR	NAI HOSPITAI		Inlie	u of Form CMS-2	2552_10
	IS OF HOSPITAL-BASED RHC/FOHC COSTS	TATRITEED MEMOR	Provi der C	CN: 14-1311	Peri od:	Worksheet M-1	
				CCN: 14-8500	From 07/01/2022 To 06/30/2023		pared:
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	1, 580, 242	0				1.00
2. 00	Physician Assistant	322, 460	0	, .		322, 309	2.00
3.00	Nurse Practitioner	465, 730	0	465, 7		465, 593	3.00
4.00	Visiting Nurse	0	0	1	0	0	1
5.00	Other Nurse	0	0	1	0 0	0	5.00
6.00	Clinical Psychologist Clinical Social Worker	250 001	0	250.0	0	0	6. 00 7. 00
7. 00 8. 00	Laboratory Technician	250, 881 0	0	250, 8	31 -4, 040 0 0	246, 841 0	
9. 00	Other Facility Health Care Staff Costs		0		0 0	0	•
10.00	Subtotal (sum of lines 1 through 9)	2, 619, 313	0	1	0		
11. 00	Physician Services Under Agreement	2,017,313	0	_, _, , , ,	13 -4, 370 0 0	2,014,917	1
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13. 00	Other Costs Under Agreement		0			0	13.00
14. 00	Subtotal (sum of lines 11 through 13)		0		0 0	0	14.00
15. 00	Medical Supplies	0	239, 328	1	28 0	239, 328	
16. 00	Transportation (Health Care Staff)	o	38, 044			38, 044	
17.00	Depreciation-Medical Equipment	0	0	1	0 0	0	17.00
18.00	Professional Liability Insurance	o	0		0 0	0	18.00
19.00	Other Health Care Costs	o	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	277, 372	277, 3	72 0	277, 372	21.00
22.00	Total Cost of Health Care Services (sum of	2, 619, 313	277, 372	2, 896, 6	-4, 396	2, 892, 289	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			T		_	
23. 00	Pharmacy	0	0	1	0 0	0	23.00
24. 00	Dental	0	0		0 0	0	24.00
25. 00	Optometry	0	0		0 5 745	0	25.00
25. 01	Tel eheal th	0	0		0 5, 745	5, 745	25. 01 25. 02
25. 02 26. 00	Chronic Care Management All other nonreimbursable costs	0	0		0 0	0	26.00
26.00	Nonallowable GME costs		Ü		0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23		0		0 5, 745	5, 745	•
20.00	through 27)		0	1	5, 745	3, 743	20.00
	FACILITY OVERHEAD			1			
29. 00	Facility Costs	0	13, 288	13, 2	88 0	13, 288	29. 00
30. 00	Administrative Costs	1, 618, 846	378, 539				30.00
31.00	Total Facility Overhead (sum of lines 29 and		391, 827		·		31.00
	30)		•				

4, 238, 159

4, 907, 358

81, 481

669, 199

32.00

4, 988, 839

32.00 Total facility costs (sum of lines 22, 28 and 31)

	Financial Systems IS OF HOSPITAL-BASED RHC/FQHC COSTS	FAIRFIELD MEMOI	Provi der CC	:N: 14-1311	Peri od:	u of Form CMS Worksheet M-	
71101213	TO OF HOSPITINE BROED WHO F WHO GOODS		Component C		From 07/01/2022 To 06/30/2023		repared:
					RHC I	Cost	
		Adjustments	Net Expenses		<u> </u>		
			for				
			Allocation				
			(col. 5 +				
			col . 6)				
		6. 00	7. 00				
4 00	FACILITY HEALTH CARE STAFF COSTS		4 500 474				4 00
1.00	Physi ci an	0	,				1.00
2.00	Physician Assistant	0	//				2.00
3.00	Nurse Practitioner	0	465, 593				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	24/ 041				6.00
7. 00 8. 00	Clinical Social Worker	0	246, 841				7. 00 8. 00
9. 00	Laboratory Technician Other Facility Health Care Staff Costs	0	١				9.00
10.00	Subtotal (sum of lines 1 through 9)	0					10.00
	Physician Services Under Agreement	0	2,014,917				11.00
	Physician Supervision Under Agreement	0					12.00
	Other Costs Under Agreement	0					13.00
	Subtotal (sum of lines 11 through 13)						14.00
	Medical Supplies		239, 328				15.00
	Transportation (Health Care Staff)	0	38, 044				16.00
	Depreciation-Medical Equipment	0	0				17.00
	Professional Liability Insurance	0					18.00
	Other Health Care Costs	0					19.00
	Allowable GME Costs						20.00
	Subtotal (sum of lines 15 through 20)	0	277, 372				21.00
22. 00	Total Cost of Health Care Services (sum of	0					22. 00
	lines 10, 14, and 21)	_	_, _, _, _,				
	COSTS OTHER THAN RHC/FQHC SERVICES	'	'				
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	o				24.00
25.00	Optometry	0	o				25. 00
25. 01	Tel eheal th	0	5, 745				25. 01
	Chronic Care Management	0	0				25. 02
	All other nonreimbursable costs	0	0				26.00
27 00	Name I I amak I a CME anata	1	1				1 27 00

5, 745

13, 288 1, 568, 369

1, 581, 657

4, 479, 691

-509, 148

-509, 148

-509, 148

25.02 26. 00 27. 00

28.00

29. 00

30.00

31.00

32.00

through 27) FACILITY OVERHEAD

Administrative Costs

29.00 Facility Costs

and 31)

30)

Nonallowable GME costs

26.00 27.00

28.00

30.00

31.00

32.00

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Heal th	Financial Systems	FAIRFIELD MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 10	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		T				
1. 00	Physi ci an	2. 97					1.00
2.00	Physician Assistant	2. 42	•				2.00
3.00	Nurse Practitioner	4. 48	•				3. 00
4. 00	Subtotal (sum of lines 1 through 3)	9. 87	•		26, 964	· ·	4. 00
5.00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	2. 40	•			2, 240	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	12. 27	24, 286			29, 204	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOCDITAL DACI	ED DUC/FOUR CEI	2)// 050		1. 00	
	Total costs of health care services (from Wk			RVICES		2, 892, 289	10.00
	Total nonreimbursable costs (from Wkst. M-1,						11.00
12.00	Cost of all services (excluding overhead) (s						
12.00	Ratio of hospital-based RHC/FQHC services (I					2, 898, 034 0. 998018	
14. 00				ino 21)			
15. 00	Total hospital-based RHC/FQHC overhead - (fr Parent provider overhead allocated to facili			The 31)		1, 581, 657	
16. 00	Total overhead (sum of lines 14 and 15)	ty (see Instru	Ctrons)			3, 591, 468 5, 173, 125	
	Allowable GME overhead (see instructions)					5, 173, 125	1
	Enter the amount from line 16					5, 173, 125	
	Overhead applicable to hospital-based RHC/FQ	NUC sorvices (1)	ino 12 y lino	10)		5, 173, 125	
	Total allowable cost of hospital-based RHC/F					8, 055, 161	
20.00	Tiotal allowable cost of hospital-based knc/r	CITO SELVICES (	Juli DI TITICS I	J anu 17)	l	0,000,101	<sub>1</sub> 20.00

<u>Heartn</u>	Financial Systems FAIRFIELD MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1311	Peri od:	Worksheet M-3	
SERVI (	CES	Component CCN: 14-8500	From 07/01/2022 To 06/30/2023	Date/Time Pre	nared:
			30, 30, 2020	11/29/2023 10	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		8, 055, 161	1.00
2.00	Cost of injections/infusions and their administration (from W			78, 580	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	ninus line 2)		7, 976, 581	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			29, 204	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6. 00	Total adjusted visits (line 4 plus line 5)			29, 204	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		0.1	273. 13	7.00
			Cal cul ati on	OT LIMIT (I)	
			Rate Period 1		
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	) 6 or your contractor)	1. 00	2. 00 296. 67	8.00
9. 00	Rate for Program covered visits (see instructions)	or or your contractor)	273. 13	273. 13	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	contractor records)	3, 157	3, 158	10.00
11.00	Program cost excluding costs for mental health services (line	*	862, 271	862, 545	
12.00	Program covered visits for mental health services (from contr	•	57	58	
13.00	Program covered cost from mental health services (line 9 x li	*	15, 568	15, 842	
14.00	Limit adjustment for mental health services (see instructions		15, 568	15, 842	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	1, 756, 226	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re	•	J	926, 329	
16. 02	Total program preventive charges (see instructions) (from prov			96, 178	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		182, 344	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		1, 167, 362	
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	1, 349, 706	
17.00	Primary payer amounts			0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(Trom contractor		114, 680	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		142, 809	19.00
17.00	records)	(110 00111140101		112,007	17.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1, 349, 706	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		54, 473	21.00
22. 00				1, 404, 179	
23. 00	Allowable bad debts (see instructions)			72, 064	
23. 01	Adjusted reimbursable bad debts (see instructions)			46, 842	
	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Tuctions)		61, 750 0	
	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
25. 99	Demonstration payment adjustment amount before sequestration	,		0	
	Net reimbursable amount (see instructions)			1, 451, 021	
26. 01	Sequestration adjustment (see instructions)			29, 020	1
26. 02				0	
27. 00	Interim payments			1, 356, 273	
28. 00	,	00 07		0	28.00
	Balance due component/program (line 26 minus lines 26.01, 26.			65, 728	
29. 00 30. 00	Protested amounts (nonallowable cost report items) in accorda	noo with CMC Dub 15 11		25, 222	30.00

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od:	Worksheet M-4	
		Component (		From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 10	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	2, 614, 917 0. 000451	2, 614, 91 0. 00214	· · ·	2, 614, 917 0. 000000	1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 179	5, 61	7 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	10, 842	10, 57	78 0	0	4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	12, 021 2, 892, 289	16, 19 2, 892, 28		0 2, 892, 289	5. 00 6. 00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	5, 162, 872 0. 004156	5, 162, 87 0. 00559		5, 162, 872 0. 000000	7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	21, 457 33, 478	28, 90 45, 10		0	9. 00 10. 00
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	69 485. 19	32 137. 0	0. 00	0 0. 00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	60	18	0	0	
13. 01 14. 00	Number of COVID-19 vaccine injections/infusions administered to MA enrollees Program cost of injections/infusions and their	29, 111	25, 3 <i>6</i>	.2	0	
14.00	administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	27, 111	23, 30	52 0	O	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	f columns 1,		78, 580	15. 00
1/ 00	Total Program cost of injections/infusions and their admin		· (oum of		54, 473	14 00

Health Financial Systems	FAIRFIELD MEMORIA	In Lieu of Form CMS-2552-10		
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 14-1311 Component CCN: 14-8500	Peri od: From 07/01/2022 To 06/30/2023	
			DUO I	0 !

				11/29/2023 10:	: 22
			RHC I	Cost	
			Par	Part B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			1, 356, 273	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount			3.	
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3
)2				0	3
)3				0	3
)4				0	3
)5				0	3
	Provider to Program				
0				0	3
1				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.		0	3	
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		1, 356, 273	4	
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	5
)2				0	5
)3				0	5
	Provider to Program				
0				0	5
1				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			65, 728	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			1, 422, 001	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor				8