Heal th Financi				u of Form CMS-2552-10
	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai since the beginning of the cost reporting period being			FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION T SUMMARY	Provider CCN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/27/2021 8:18 pm
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost report		Date: 7/27/20	21 Time: 8:18 pm
use only	 2. [] Manually prepared cost report 3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "L 	of times the provider r " for low.	esubmitted this co	ost report
Contractor use only	5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	10.1 11.0 pr this Provider CCN 12.	NPR Date: Contractor's Vendo [0]If line 5, cc number of tim	or Code: 4 Jumn 1 is 4: Enter les reopened = 0-9.
PART II - CER	TI FI CATI ON			
ADMINISTRATIV PROVIDED OR P ADMINISTRATIV	TION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN T E ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. ROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A E ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. FICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF	FURTHERMORE, IF SERVICES KICKBACK OR WERE OTHER	S IDENTIFIED IN TH	IIS REPORT WERE
	REBY CERTIFY that I have read the above certification st		examined the acco	ompanyi ng
el ect Exper begi r are t appl i regar provi	cronically filed or manually submitted cost report and t ases prepared by Laffayette Regional Rehabilitation Hosp uning 01/01/2020 and ending 12/31/2020 and to the best of crue, correct, complete and prepared from the books and cable instructions, except as noted. I further certify ding the provision of health care services, and that the ded in compliance with such laws and regulations.	the Balance Sheet and St. bital (15-3042) for the of my knowledge and beli- records of the provider that I am familiar wit be services identified i	atement of Revenue e cost reporting p ef, this report ar in accordance with h the laws and reg n this cost report	e and beriod nd statement th gulations t were
[X]	I have read and agree with the above certification stats ignature on this certification statement to be the leg			
	(Si gned)		strator of Provid	er(s)
		CF0 Title		
		(Dated when report Date	is electronicall	y signed.)

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	996	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	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	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	996	0	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving 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.

11	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DA	ATA	Provid	er CCN:	15-3042	Period: From 01/0		Part I	eet S-2	
							To 12/3	1/2020		ime Pre 021 8:1	
	1.00		. 00		3.00			4.00			_
	<u>Hospital and Hospital Health Care Co</u> Street: 950 Park East Blvd	PO Box:									1
	City: Lafayette	State:	IN	Zip Code	e: 47905	5 Cour	nty: TIPPECA	NOE			2
		Component N	ame	CCN	CBSA				ent Sys		
				Number	Numbe	r Type	Certifie		<u>,</u> 0, or XVIII		-
		1.00		2.00	3.00	4.00	5.00	6.00	_		1
	Hospital and Hospital-Based Componen		:								
)	Hospi tal	Laffayette Regic		153042	29200	5	04/18/201	3 N	P	P	3
)	Subprovider - IPF	Rehabilitation H	iospi tai								4
	Subprovider - IRF										5
)	Subprovider - (Other)										6
	Swing Beds - SNF										7
	Swing Beds - NF Hospital-Based SNF										8
	Hospi tal -Based NF										10
	Hospital-Based OLTC										11
	Hospital-Based HHA										12
	Separately Certified ASC Hospital-Based Hospice										13
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC										16
	Hospital-Based (CMHC) I										17
	Renal Dialysis Other										18
,0							Fro	m:	To	D:	
							1.0			00	
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/		12/31	/2020	20
0	Type of control (see this tructrolis)						4				21
						1.00	2.0	00	3.	00	
~	Inpatient PPS Information					N					
00	Does this facility qualify and is it disproportionate share hospital adju					Ν	N				22
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §			dment							
)1	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un			for thi	e	Ν	N				22
,	cost reporting period? Enter in colu					IN					22
	the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				ost						
)2	reporting period occurring on or aft Is this a newly merged hospital that				e	Ν	N				22
	payments to be determined at cost re										22
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of th October 1.	e cost reporting	heiron o	ni ur art							
)3	Did this hospital receive a geograph					Ν	N		1	N	22
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for	no for the portio	on of the	cost	·						
	reporting period occurring on or aft										
	Does this hospital contain at least counted in accordance with 42 CFR 41										
	yes or "N" for no.	2. 105)? Enter Th	COLUMN 3	, r io	1						
	Which method is used to determine Me						2 N				23
	below? In column 1, enter 1 if date if date of discharge. Is the method										
	reporting period different from the				USI						
	reporting period? In column 2, ente		"N" for	no.							
			In-Stat			Out-of	Out-of	Medi ca)ther	
			Medicai paid day			State Medicaid	State Medi cai d	HMO da	- I	di cai d days	
						bai d days	eligible				
				day	,	-	unpai d				
00	If this provider is an LDDC base !!!	optor the	1.00	2.0	0	3.00	4.00	5.00		6.00	
JU	If this provider is an IPPS hospital in-state Medicaid paid days in colum			0	0	0	0		0	C	24
	Medicaid eligible unpaid days in col										
			1	1							1
	out-of-state Medicaid paid days in c										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	d days in column									

	<u>Financial Systems</u> <u>Laffayette Regi</u> AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		Peri od:	In Lieu	Worksh	et S-2	
					From 01/0	1/2020 1/2020	Part I	ime Pre	epare
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Me	ther di cai d days	
00	If this provider is an IRF, enter the in-state 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.	<u>1.00</u> 191	2.00	3.00	4.00		373	5.00	25
					1.	ural S DO	Date of 2.		
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural. age) status "2" for r	at the end ural. If ap	d of the cos		1			26
00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35
					Begi n 1.		Endi 2.		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date	es.	·						36
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	ne MDH tran	sitional pa	ayment in	5	0			37
00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	s of MDH st	atus. Ifli	ne 37 is					38
					Y/ 1.		۲ <i>/</i> 2.		
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reductior "N" for no in column 1, for discharges prior to Octob	, (ii), or the mileage i)? Enter n adjustmen	(iii)? Ent requiremen in column 2 t? Enter "Y	er in colum nts in ? "Y" for ye (" for yes o	me M n s r M		۲ ۱	l	39 40
	no in column 2, for discharges on or after October 1.						XVIII	XIX	
	Dreenestive Devent System (DDC) Conited					1.00	_	3.00	1
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					N	N	N N	45
00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c	·			5	N	N	N	47
00	Is the facility electing full federal capital payment Teaching Hospitals	:? Enter "	Y" for yes	or "N" for	no.	N	N	N	48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for	mpacted by no in colu period duri	CR 11642 (mn 2. ng which re	(or subseque esidents in	nt CR), MA approved				56
00	is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	th of this (", complet , if appli	cost report e Worksheet cable.	ing period? E-4. If co	Enter "Y lumn 2 is				58
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	complete W	kst. D-5.		- 45	N			59
00	Are costs channed on the too of worksheet A: Thyes	<u>s, comprete</u>	WKST. D-2,	NAHE 413. 8 Y/N	35 Worksh Lin	eet A e #	Pass-T Qualifi Criteri	cation	
				1.00	2.	00	3.	00	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (see umn 1. If CR) NAHE MA	column 1	N					60

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TΑ	Provider C		eriod: rom 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/27/2021 8:15	pared
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	1
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.0
	column 1. (see instructions)						
. 01	Enter the average number of unweighted primary care						61.0
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						
	instructions)						
1.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61.
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61.
	determining compliance with the 75% test. (see						
	instructions)						
. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.
	current cost reporting period. (see instructions).						
. 05	Enter the difference between the baseline primary						61.
	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)						
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.
	care or general surgery. (see instructions)						
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE	
						Count	
			1.00	2.00	3.00	4.00	
. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0.00	61.
	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.						
. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0.00	0.00	61.
	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 Ser	rvices A	dministration	(HRSA)		1.00	
. 00	Enter the number of FTE residents that your hospital		in this cost	reporting peri	od for which	0.00	62.
2. 01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a		ng Health Cen	ter (THC) into	vour hospital	0.00	62.
	during in this cost reporting period of HRSA THC proc	gram. (s	ee instructio				
8. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se			ost reporting r	eriod? Enter	N	63.
. 00	"Y" for yes or "N" for no in column 1. If yes, comple					iv.	00.
				Unweighted	0	Ratio (col. 1/ (col. 1 + col.	r
				FTEs Nonprovider	FTEs in Hospital	(001. 1 + 001. 2))	
				Si te			
	Saction 5504 of the ACA Pace Year ETE Decidents in No	opprovid	lor Sottings	1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			nnis base year	is your cost r	eporting	
				0.00	0.00	0. 000000	64.
. 00	Enter in column 1, if line 63 is yes, or your facilit			0.00	0.00		
. 00	in the base year period, the number of unweighted nor	n-primar	y care	0.00	0.00		
. 00		n-primar all non	y care provi der	0.00	0.00		

SPITAL AND HOSPITAL HEALTH CARE COMPL	LEX IDENTIFICATION DA	ATA Provi der		riod: om 01/01/2020	Worksheet S-2 Part I	
			To			epared
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
	-		FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der Si te	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.00	-
.00 Enter in column 1, if line 63		2100	0.00	0.00		65.0
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)						
		<u> </u>	Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTES	FTEs in	$(col \cdot 1 + col \cdot$	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settir				
00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of	ccurring in all nonp	rovider settings.	0.00	0. 00	0. 000000	66.0
FTEs that trained in your hospit		3 the ratio of				
FTEs that trained in your hospit (column 1 divided by (column 1 +	column 2)). (see in	3 the ratio of structions)	Unweighted	Unwei ahted	Ratio (col. 3/	/
		3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(column 1 divided by (column 1 +	column 2)). (see in	3 the ratio of structions)	FTĔs Nonprovi der	FTEsin	(col. 3 + col. 4)) 5.00	_
(column 1 divided by (column 1 +	<u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
(column 1 divided by (column 1 + (column 1 divided by (column 1 + 00 Enter in column 1, the program 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	<u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col . 3 + col . 4)) 5.00 0 0.000000	_
(col umn 1 divided by (col umn 1 + (col umn 1 divided by (col umn 1 + name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions)	<u>column 2)). (see in</u> Program Name <u>1.00</u>	3 the ratio of structions) Program Code 2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00	(col . 3 + col . 4)) 5.00 0 0.000000	0 67.
(col umn 1 divided by (col umn 1 + 00 Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions) 00 Inpatient Psychiatric Facility P 00 Is this facility an Inpatient Psychiatric For N" for not provide to prime provide prime prime provide to prime provide to prime prim	<u>column 2)). (see in</u> Program Name <u>1.00</u> <u>98</u> ychiatric Facility (3 the ratio of structions) Program Code 2.00 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00 0.00 1.0 rovider? N	(col . 3 + col . 4)) 5.00 0 0.000000	0 67.0
<pre>(col umn 1 divided by (col umn 1 + (col umn 1 divided by (col umn 1 + name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions)</pre>	<u>column 2)). (see in</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	3 the ratio of structions) Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 itain an IPF subpl sing program in th yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0 0.000000	70.
 (col umn 1 divided by (col umn 1 + (col umn 1 divided by (col umn 1 + (col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 3 divided by (col umn 3 divided by (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions) Inpatient Psychiatric Facility P 0.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no 1f line 70 is yes: Col umn 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF col umn 3: If col umn 2 is Y, individent and the col umn 2 is Y, individent and the col umn 2 is Y, individent and the col umn 4. 	<u>column 2)). (see in</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1</u>	3 the ratio of structions) Program Code 2.00 1PF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subplication sing program in the yes or "N" for me s cost reporting	FTES in Hospital 4.00 0.00 1.0 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0.0000000 0.00000000000000000000	_

Health Financial Systems	Laffayette Regional Re			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet S- Part I Date/Time Pr 7/27/2021 8:	epared:
					1.00	_
Long Term Care Hospital PPS 80.00 Is this a long term care hospital 81.00 Is this a LTCH co-located within "Y" for yes and "N" for no.				g period? Enter	N N	80.00 81.00
TEFRA Providers85.00Is this a new hospital under 42 086.00Did this facility establish a new	Other subprovider (exclude		2		N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for 87.00 Is this hospital an extended neop 1886(d)(1)(P)(vi)? Enter "Y" for	lastic disease care hospita	l classi fied	under section		N	87.00
1886(d)(1)(B)(vi)? Enter "Y" for				V 1.00	XI X 2.00	
90.00 Does this facility have title V a	nd/or XIX inpatient hospita	I services? E	nter "Y" for	N	N	90.00
yes or "N" for no in the applicat 91.00 Is this hospital reimbursed for t	itle V and/or XIX through t			N	N	91.00
full or in part? Enter "Y" for ye 92.00 Are title XIX NF patients occupyi	ng title XVIII SNF beds (du	al certificat			N	92.00
93.00 Does this facility operate an ICF	/IID facility for purposes		d XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the 94.00 Does title V or XIX reduce capita applicable column.	applicable column. I cost? Enter "Y" for yes,	and "N" for n	o in the	Ν	N	94.00
95.00 If line 94 is "Y", enter the redu 96.00 Does title V or XIX reduce operat				0. 00 N	0. 00 N	95.00 96.00
applicable column. 97.00 If line 96 is "Y", enter the redu 98.00 Does title V or XIX follow Medica stepdown adjustments on Wkst. B,	re (title XVIII) for the in Pt. I, col. 25? Enter "Y" f	iterns and res	idents post	0. 00 Y	0. 00 Y	97.00 98.00
<pre>column 1 for title V, and in colu 98.01 Does title V or XIX follow Medica C, Pt. I? Enter "Y" for yes or "N </pre>	re (title XVIII) for the re			. Y	Y	98. 01
 title XIX. 98.02 Does title V or XIX follow Medica bed costs on Wkst. D-1, Pt. IV, I 	ine 89? Enter "Y" for yes o			Y	Y	98. 02
98.03 for title V, and in column 2 for 98.03 Does title V or XIX follow Medica reimbursed 101% of inpatient serv	re (title XVIII) for a crit ices cost? Enter "Y" for ye				N	98.03
98.04 for title V, and in column 2 for 98.04 Does title V or XIX follow Medica outpatient services cost? Enter "	re (title XVIII) for a CAH			Ν	N	98.04
<pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medica Wkst. C, Pt. I, col. 4? Enter "Y"</pre>					Y	98. 05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medica Pts. I through IV? Enter "Y" for column 2 for title XIX.</pre>	re (title XVIII) when cost yes or "N" for no in column	reimbursed fo 1 for title	r Wkst. D, V, and in	Y	Y	98.06
Rural Providers 105.00 Does this hospital qualify as a C				. N		105.00
106.00 If this facility qualifies as a C for outpatient services? (see ins	tructions)		1 5	t		106.00
107.00 Column 1: If line 105 is Y, is th training programs? Enter "Y" for Column 2: If column 1 is Y and I approved medical education progra	yes or "N" for no in column ine 70 or line 75 is Y, do m in the CAH's excluded IP	1. (see ins you train I&R F and/or IRF	tructions) s in an			107.00
Enter "Y" for yes or "N" for no i 108.00 Is this a rural hospital qualifyi CFR Section §412.113(c). Enter "Y	ng for an exception to the		dul e? See 42	N		108. 00
		Physi cal 1.00	Occupationa 2.00	I Speech 3.00	Respiratory 4.00	_
109.00 If this hospital qualifies as a C therapy services provided by outs for yes or "N" for no for each th	ide supplier? Enter "Y"	1.00	2.00	5.00	4.00	109.00
					1.00	_
110.00Did this hospital participate in Demonstration)for the current cos complete Worksheet E, Part A, lin	t reporting period? Enter "	Y" for yes or	"N" for no.	lf yes,	N	110.00
appl i cabl e.						

Health Financial Systems	Laffayette Regional Rehal	oilitation ⊦	lospi	In Lieu	u of Form CMS-	-2552-10
HOSPI TAL AND HOSPI TAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC		eriod: com 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/27/2021 8:2	epared:
				1.00	2.00	-
111.00 If this facility qualifies as a CA Health Integration Project (FCHIP) "Y" for yes or "N" for no in colur integration prong of the FCHIP der Enter all that apply: "A" for Ambu for tele-health services.) demonstration for this cost nn 1. If the response to colur no in which this CAH is partic	reporting p nn 1 is Y, e cipating in	eriod? Enter enter the column 2.	N		111.00
			1.00	2.00	3.00	-
112.00 Did this hospital participate in a demonstration for any portion of a Enter "Y" for yes or "N" for no in in column 2, the date the hospital demonstration. In column 3, enter participation in the demonstration Miscellaneous Cost Reporting Information and the demonstration of the demonstratic of the demonstration of t	the current cost reporting per n column 1. If column 1 is "\ began participating in the the date the hospital ceased n, if applicable.	riod? (", enter	N	2.00	3.00	112.00
115.00 Is this an all-inclusive rate prov		l" for no	N		1	0115.00
in column 1. If column 1 is yes, e in column 2. If column 2 is "E", e for short term hospital or "98" pe psychiatric, rehabilitation and lo the definition in CMS Pub. 15-1, ch	enter the method used (A, B, c enter in column 3 either "93" ercent for long term care (inc ong term hospitals providers)	or E only) percent cludes				
116.00 Is this facility classified as a m		yes or	Ν			116. 00
"N" for no. 117.00 Is this facility legally-required "Y" for yes or "N" for no.	to carry malpractice insurance	ce? Enter	Ν			117.00
118.00 Is the malpractice insurance a cla if the policy is claim-made. Enter			0			118.00
118.01 List amounts of malpractice premiu	ums and paid losses:		Premi ums 1.00 0	Losses 2.00 0	I nsurance	0118.01
· · · ·	•					_
118.02 Are malpractice premiums and paid	losses reported in a cost cer	nter other t	han the	1.00 N	2.00	118.02
Administrative and General? If ye and amounts contained therein. 119.00 D0 NOT USE THIS LINE						119.00
120.00 Is this a SCH or EACH that qualifi §3121 and applicable amendments? "N" for no. Is this a rural hospit Hold Harmless provision in ACA §3 Enter in column 2, "Y" for yes or	(see instructions) Enter in co tal with < 100 beds that quali 121 and applicable amendments?	olumn 1, "Y" fies for th	for yes or e Outpatient	Ν	Ν	120.00
121.00 Did this facility incur and report	t costs for high cost implanta	able devices	charged to	Ν		121.00
patients? Enter "Y" for yes or "N" 122.00 Does the cost report contain heal Act?Enter "Y" for yes or "N" for i the Worksheet A line number where Transplant Center Information	thcare related taxes as define no in column 1. If column 1 is			Ν		122.00
125.00 Does this facility operate a trans yes, enter certification date(s)		es and "N"	for no. If	Ν		125.00
126.00 If this is a Medicare certified ki in column 1 and termination date,	dney transplant center, enter	the certif	ication date			126. 00
127.00 If this is a Medicare certified he in column 1 and termination date,	eart transplant center, enter	the certifi	cation date			127.00
128.00 If this is a Medicare certified li in column 1 and termination date,	ver transplant center, enter	the certifi	cation date			128.00
129.00 If this is a Medicare certified to column 1 and termination date, if	ung transplant center, enter t	the certific	ation date in			129. 00
130.00 If this is a Medicare certified pa	ancreas transplant center, ent		i fi cati on			130. 00
date in column 1 and termination of 131.00 If this is a Medicare certified in date in column 1 and termination of	ntestinal transplant center, e	enter the ce	rti fi cati on			131.00
132.00 If this is a Medicare certified is in column 1 and termination date,	slet transplant center, enter		cation date			132.00
133.00 Removed and reserved 134.00 If this is an organ procurement or)P0 number i	n column 1			133.00 134.00
and termination date, if applicabl						-
140.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column 1. If yes	s, and home	office costs	Y	HB1609	140.00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			<u>pilitation H</u> Provider CCI				: 1/01/2020 2/31/2020		repared:
1.00		2.00					3.00	7/27/2021 8:	18 pm
If this facility is part of a chai	n organization, enter		es 141 throu	ah 143	the n	ame and		of the	
home office and enter the home of 41.00Name: ERNEST HEALTH INC		nd cont	ractor numbe	<u>r.</u>			mber: 0401		141.00
42.00 Street: PO BOX 93758	PO Box:								142.00
43.00 City: ALBUQUERQUE	State:	NM		Zip	Code		8719	9	143.00
								1.00	_
144.00 Are provider based physicians' cos	sts included in Workshe	et A?						N 1.00	144.00
							1.00	2.00	
45.00 f costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility in	' for yes or "N" for no clude Medicare utilizat	o in col	umn 1. If c	olumn 1			Y		145.00
period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	gy changed from the pre n column 1. (See CMS Pu						Ν		146.00
								1.00	
47.00 Was there a change in the statisti 48.00 Was there a change in the order of								N N	147.00 148.00
49.00 Was there a change to the simplifi					" for	no		N	148.00
	ou coor innung mothod		Part A		t B		ïtle V	Title XIX	
			1.00	2.			3.00	4.00	
Does this facility contain a prov									
or charges? Enter "Y" for yes or ' 55.00 Hospi tal	<u>'N" for no for each con</u>	nponent	N N		<u>rt B.</u> N	(See 42	<u>2 CFR §413</u> N	. 13) N	155. 0
56. 00 Subprovi der – TPF			N	' N			N	N	156.0
57.00 Subprovi der - IRF			N	ľ	J		Ν	N	157.00
58. 00 SUBPROVI DER									158.00
59.00 SNF			N	1			N	N	159.00
60. 00 HOME HEALTH AGENCY 61. 00 CMHC			N	1 1			N N	N N	160.00
			I	1	v		IN	11	101.00
								1.00	
Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or	r more campu	ses in	di ffe	rent CE	3SAs?	N	165. 00
	Name		County	State		p Code	CBSA	FTE/Campus	
	0		1.00	2.00		3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0. (00 166. 00
								1.00	
Health Information Technology (HI						t Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a mea	ani ngful				, enter	the	N	167. 0 168. 0
68.01 If this provider is a CAH and is r	not a meaningful user,	does th				a hard	lshi p		168. 0
exception under §413.70(a)(6)(ii)' 69.00 If this provider is a meaningful u	user (line 167 is "Y")					"N"), e	enter the	0.0	00169.00
transition factor. (see instruction	лтэ <i>)</i>					Be	gi nni ng	Endi ng	
							1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	beginning date and endi	ng date	e for the re	porting					170.00
							1.00	2.00	-
171.00 fline 167 is "Y", does this prov section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu	reported on Wkst. S-3,	Pt. I,	line 2, col	. 6? En		n	N		0 171. 00

Health Financial Systems Laffayette Regional Rehabilitation Hospi In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 15-3042 Peri od: Worksheet S-2 From 01/01/2020 Part II Date/Time Prepared: То 12/31/2020 7/27/2021 8:18 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 γ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Υ 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 05/05/2021 05/05/2021 16.00 Υ γ 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Ν Ν 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

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In Lieu of Form CMS-2552-10

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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 no, see instructions. 33.00 Provider-Based Physicians 34.00 At provider-Based Physicians 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? 34.00 If yes, see instructions. Y/N Date physicians during the cost reporting period? If yes, see instructions. 35.00 Home Office Costs 1.00 2.00 Box of the provider I have a home office cost scalamed on the cost report? 36.00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office. 38.00 1.00 2.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 39.00 If line 36 is yes, did the provider render services to the home office? 39.00 39.00 If line 36 is yes, did the provider render services to the home office? 39.00 39.00 If line 36 is yes, did the provider render services to the home office? 39.00 39.00 If line 36 is yes, did the provider render services to the home office? 41.00							
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34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 34.00 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. Y/N Date 36.00 Were home office costs 1.00 2.00 36.00 Were home office costs claimed on the cost report? 36.00 37.00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 38.00 If line 36 is yes, other in column 2 the fiscal year end of the home office? If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 30.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 40.00 40.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Nary Pitcock 41.00 42.00 Enter the telephone number and email address of the cost 903-588-0077 marykay@ernesthealth.com 43.00	33.00		plied pertaini	ng to competi	tive bidding? If		33.00
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 25.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 26.00 Were home office costs Y/N Date 36.00 Were home office costs claimed on the cost report? 1.00 2.00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 36.00 37.00 38.00 If line 36 is yes, on 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 38.00 30.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 30.00 If line 36 is yes, did the provider render services to the home office? 40.00 31.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Mary Pi tcock 41.00 42.00 Enter the telephone number and email address of the cost 903-588-0077 marykay@ernesthealth.com 43.00							
35.00 If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. 35.00 35.00 V/N Date 1.00 2.00 Home Office Costs Were home office costs claimed on the cost report? 36.00 37.00 If I ine 36 is yes, has a home office cost statement been prepared by the home office? 36.00 If yes, see instructions. 38.00 If line 36 is yes, onter in column 2 the fiscal year end of the home office. 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 40.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00	34.00		irrangement with	h provider-ba	sed physi ci ans?		34.00
physicians during the cost reporting period? If yes, see instructions. Y/N Date V/N Date 1.00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? 36.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 36.00 37.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, see instructions. 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 39.00 Adv colspan="2">Adv colspan="2">Preparer Contact Information Mary Pitcock 41.00 Adv colspan="2">Cost Report Preparer Contact Information Adv colspan="2">Adv colspan="2"							

Heal th	Financial Systems	Laffayette Regional	Reha	abilitation Hosp	Di	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEN	IENT QUESTI ONNAI RE		Provider CCN:	15-3042	Peri od:	Worksheet S-2	
						From 01/01/2020 To 12/31/2020		pared: 8 pm
				3.00				
	Cost Report Preparer Contact Informat	i on						
41.00	Enter the first name, last name and t	he title/position	Sr.	Reimbursement	Anal yst			41.00
	held by the cost report preparer in c	olumns 1, 2, and 3,						
	respectively.							
42.00	Enter the employer/company name of th	e cost report						42.00
	preparer.							
43.00	Enter the telephone number and email	address of the cost						43.00
	report preparer in columns 1 and 2, r	especti vel y.						

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e		I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	40	14, 64		0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT		40	14, 64	0.00	0	6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14. 00 15. 00 16. 00 17. 00 18. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF		40	14, 64	.0 0.00	0	14. 00 15. 00 16. 00 17. 00 18. 00
19. 00 20. 00 21. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	44.00	0		0	0	19.00 20.00 21.00
22.00 23.00 24.00 24.10	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE (pop distinct part)	101. 00 30. 00				0	22.00 23.00 24.00 24.10
25.00 26.00 26.25	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	24. 10 25. 00 26. 00 26. 25
20. 23 27. 00 28. 00 29. 00 30. 00 31. 00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	87.00	40			0	27.00
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days		Ο		0		32.00 32.01 33.00

PITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC			Provider CCN: 15-3042		Worksheet S-3 Part I Date/Time Pre 7/27/2021 8:1	pare	
	I/P Days	/ O/P Visits	/ Trips	Full Time Equivalents			
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
0 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4, 658	191	7, 43	1		1.	
0 HMO and other (see instructions)	1, 181	473				2.	
0 HMO I PF Subprovider	0	0				3.	
0 HMO IRF Subprovider	0	0				4.	
0 Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.	
0 Hospital Adults & Peds. Swing Bed NF		0		0		6.	
0 Total Adults and Peds. (exclude observation beds) (see instructions)	4, 658	191	7,43	1		7.	
0 INTENSIVE CARE UNIT						8	
0 CORONARY CARE UNIT						9	
00 BURN INTENSIVE CARE UNIT						10	
00 SURGI CAL I NTENSI VE CARE UNI T						11	
00 OTHER SPECIAL CARE (SPECIFY) 00 NURSERY						12	
00 Total (see instructions)	4,658	191	7, 43	1 0.00	96. 53		
00 CAH visits	4,000	0	7,43	0.00	70.00	15	
00 SUBPROVIDER - IPF		0		0		16	
00 SUBPROVIDER - IRF						17	
00 SUBPROVI DER						18	
00 SKILLED NURSING FACILITY	0	0		0.00	0.00	19	
00 NURSING FACILITY						20	
00 OTHER LONG TERM CARE						21	
00 HOME HEALTH AGENCY	0	0		0 0.00	0.00		
00 AMBULATORY SURGICAL CENTER (D. P.)						23	
				-		24	
10 HOSPICE (non-distinct part)				0		24	
00 CMHC - CMHC 00 RURAL HEALTH CLINIC						25	
00 RURAL HEALTH CLINIC 25 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00		
00 Total (sum of lines 14-26)	0	0		0.00			
00 Observation Bed Days		0		0.00	70.00	28	
00 Ambulance Trips	0	0				29	
00 Employee discount days (see instruction)				0		30	
00 Employee discount days - IRF				0		31	
00 Labor & delivery days (see instructions)	0	0		0		32	
01 Total ancillary labor & delivery room				0		32	
outpatient days (see instructions)							
00 LTCH non-covered days	0					33	
01 LTCH site neutral days and discharges	0					33	

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATĂ	Provider CC	CN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 7/27/2021 8:1	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 13.\ 00\\ 13.\ 00\\ 13.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 02\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ \end{array}$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPR	0.00 0.00 0.00 0.00 0.00	0	3	10 12 74 24 0 0 10 12	481	1. 00 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 14. 00 15. 00 14. 00 13. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00
30. 00 31. 00 32. 00 32. 01 33. 00 33. 01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		30. 00 31. 00 32. 00 32. 01 33. 00 33. 00

Heal th	Financial Systems Laffaye	ette Regional Ref	nabilitation	Hospi	In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES			Peri od:	Worksheet A	
					From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/27/2021 8:1	
	Cost Center Description	Sal ari es	Other	Total (col 1	Reclassi fi cati		
	cost center bescription	54141163	other	+ col . 2)	ons (See A-6)	Trial Balance	
				1 001. 2)		(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 647, 086	1, 647, 08	6 7, 493	1, 654, 579	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		206, 087				
3.00	00300 OTHER CAP REL COSTS		214, 221	214, 22	1 -214, 221	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	566, 318	903, 439	1, 469, 75		1, 469, 757	4.00
5.00	00500 ADMINI STRATI VE & GENERAL	1, 554, 113	1, 788, 745	3, 342, 85	8 0	3, 342, 858	5.00
7.00	00700 OPERATION OF PLANT	48, 100	408, 281				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	34, 520			34, 520	8.00
9.00	00900 HOUSEKEEPI NG	128, 130	39, 413			167, 543	
10.00	01000 DI ETARY	230, 005	181, 337			411, 342	•
13.00	01300 NURSI NG ADMI NI STRATI ON	288, 715	24,604				•
16.00	01600 MEDI CAL RECORDS & LI BRARY	28, 481	20, 186				•
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30.00	03000 ADULTS & PEDI ATRI CS	2, 144, 978	227, 527	2, 372, 50	5 0	2, 372, 505	30.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0		•
	ANCI LLARY SERVICE COST CENTERS	· · · · · ·		1	· · · · ·		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	28, 632	28, 63	2 0	28, 632	54.00
57.00	05700 CT SCAN	o	0		o o		•
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0		o o	0	58.00
60.00	06000 LABORATORY	0	89, 683	89, 68	3 0	89, 683	60.00
65.00	06500 RESPI RATORY THERAPY	96, 899	41, 922	138, 82	1 0	138, 821	65.00
66.00	06600 PHYSI CAL THERAPY	489, 360	71,094				
67.00	06700 OCCUPATI ONAL THERAPY	365, 226	36, 318				•
68.00	06800 SPEECH PATHOLOGY	145, 803	13, 958				•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 089	158, 576				1
73.00	07300 DRUGS CHARGED TO PATIENTS	199, 207	295, 193				
74.00	07400 RENAL DI ALYSI S	0	136, 595				•
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	o	137, 554	137, 55	4 0	137, 554	76.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	· · ·				1
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
91.01	04951 OUTPATI ENT THERAPY	214, 318	2, 502	216, 82	0 -216, 820	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0		93.00
	OTHER REIMBURSABLE COST CENTERS			•	·		1
95.00	09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	117.00
118.00		6, 536, 742	6, 707, 473	13, 244, 21	5 0	13, 244, 215	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	07950 MARKETI NG	0	0		0 0		194.00
194.01	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	6, 536, 742	6, 707, 473	13, 244, 21	5 0	13, 244, 215	200. 00

RECLASSI F	ICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-304	2 Period: From 01/01/2020 To 12/31/2020	Worksheet A Date/Time Prepared: 7/27/2021 8:18 pm
	Cost Center Description		Net Expenses	·	
			or Allocation		
		6.00	7.00		
	VERAL SERVICE COST CENTERS				
	100 CAP REL COSTS-BLDG & FIXT	219, 753	1,874,332		1.0
	200 CAP REL COSTS-MVBLE EQUIP	1, 200	414, 015		2.0
	300 OTHER CAP REL COSTS	0	0		3.0
	400 EMPLOYEE BENEFITS DEPARTMENT	-7, 491	1, 462, 266		4.0
	500 ADMINISTRATIVE & GENERAL	157, 646	3, 500, 504		5.0
	700 OPERATION OF PLANT	-7, 078	449, 303		7.0
3.00 008	BOO LAUNDRY & LINEN SERVICE	0	34, 520		8.0
009 009	900 HOUSEKEEPI NG	0	167, 543		9.0
0.00 010	DOO DI ETARY	-9, 016	402, 326		10.0
3.00 013	300 NURSI NG ADMI NI STRATI ON	0	313, 319		13.0
6.00 016	500 MEDI CAL RECORDS & LI BRARY	-55	48, 612		16.0
I NF	PATIENT ROUTINE SERVICE COST CENTERS	I	· · · ·		
	DOO ADULTS & PEDIATRICS	0	2, 372, 505		30.0
	400 SKILLED NURSING FACILITY	0	0		44.0
	CILLARY SERVICE COST CENTERS				
	400 RADI OLOGY-DI AGNOSTI C	0	28, 632		54.0
	700 CT SCAN	0	0		57.0
-	BOO MAGNETIC RESONANCE I MAGING (MRI)	0	o		58.0
	DOO LABORATORY	0	89, 683		60.0
	500 RESPI RATORY THERAPY	0	138, 821		65.0
-	600 PHYSI CAL THERAPY	0	591, 786		66.0
	700 OCCUPATI ONAL THERAPY	0	531, 860		67.0
	BOO SPEECH PATHOLOGY	0	214, 933		68.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-25	195, 640		71.0
	300 DRUGS CHARGED TO PATTENTS	-25	494, 400		73.0
		-			
	400 RENAL DI ALYSI S	0	136, 595		74.0
	950 OTHER ANCI LLARY SERVICE COST CENTERS	0	137, 554		76.0
	TPATIENT SERVICE COST CENTERS		2		
	100 EMERGENCY	0	0		91.0
	951 OUTPATI ENT THERAPY	0	0		91.0
	950 OUTPATIENT WOUND CENTER	0	0		93. 0
	HER REIMBURSABLE COST CENTERS				
	500 AMBULANCE SERVICES	0	0		95.0
	100 HOME HEALTH AGENCY	0	0		101. 0
SPE	ECIAL PURPOSE COST CENTERS				
17.00069	950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	354, 934	13, 599, 149		118. 0
NON	VREI MBURSABLE COST CENTERS				
	200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 0
	950 MARKETI NG	0	0		194. 0
	951 OTHER NONREI MBURSABLE COST CENTERS	0	0		194. 0
200.00	TOTAL (SUM OF LINES 118 through 199)	354, 934	13, 599, 149		200. 0

Heal th	Financial Systems	Laffay	ette Regional F	Rehabilitation	Hospi	In Lieu of Form CMS-2552-1		
RECLAS	SI FI CATI ONS			Provider C	CN: 15-3042	Peri od: From 01/01/2020 To 12/31/2020	Worksheet A- Date/Time Pr 7/27/2021 8:	epared:
		Increases						
	Cost Center	Line #	Salary	0ther				
	2.00	3.00	4.00	5.00				
	A – RCLS PCT THERAPY							
1.00	OCCUPATI ONAL THERAPY	67.00	43, 529	4, 134				1.00
2.00	SPEECH PATHOLOGY	68.00	18, 429	1, 750				2.00
	TOTALS		61, 958	5, 884				
	B - RCLS O/P THERAPY							
1.00	PHYSICAL THERAPY	66.00	98, 030	1, 144				1.00
2.00	OCCUPATI ONAL THERAPY	67.00	81, 699	954				2.00
3.00	SPEECH PATHOLOGY	68.00	34, 589	404				3.00
	TOTALS		214, 318	2,502				1
500.00	Grand Total: Increases		276, 276	8, 386				500.00

Health Financial Systems Laffayette Regional R			Rehabilitation	Hospi	In Lieu of Form CMS-2552-10			
RECLAS	SIFICATIONS			Provider (CCN: 15-3042	Period: From 01/01/2020	Worksheet A-	6
						To 12/31/2020	Date/Time Pr 7/27/2021 8:	epared: 18 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A – RCLS PCT THERAPY							
1.00	PHYSI CAL THERAPY	66.00	61, 958	5, 884		0		1.00
2.00		0.00	0	0		o		2.00
	TOTALS		61, 958	5, 884				
	B - RCLS O/P THERAPY							
1.00	OUTPATI ENT THERAPY	91.01	214, 318	2, 502		0		1.00
2.00		0.00	C	0		0		2.00
3.00		0.00	0	0		o		3.00
	TOTALS		214, 318	2, 502				
500.00	Grand Total: Decreases		276, 276	8, 386				500.00

In Lieu of Form CMS-2552-10 Worksheet A-7

		From 01/01/2020 To 12/31/2020			pared:	
			Acqui si ti on	S		
	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	T BALANCES					
1.00 Land	0	0		0 0	0	1.00
2.00 Land Improvements	0	0		0 0	0	2.00
3.00 Buildings and Fixtures	21, 647	56, 539		0 56, 539	0	3.00
4.00 Building Improvements	0	0		0 0	0	4.00
5.00 Fixed Equipment	20, 680	0		0 0	0	5.00
6.00 Movable Equipment	2, 324, 835	402, 990		0 402, 990	0	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	2, 367, 162	459, 529		0 459, 529	0	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	2, 367, 162	459, 529		0 459, 529	0	10.00
	Endi ng Bal ance	Fully				
		Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00 Land	0	0				1.00
2.00 Land Improvements	0	0				2.00
3.00 Buildings and Fixtures	78, 186	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	20, 680	0				5.00
6.00 Movable Equipment	2, 727, 825	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	2, 826, 691	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	2, 826, 691	0				10.00

Health Financial Systems Laffayette Regional Rehabilitation Hospi In Lieu of Form CMS-2552-10							2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	9, 400	1, 602, 606	35, 08	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	157, 496	48, 591		0 0	0	2.00
3.00	Total (sum of lines 1-2)	166, 896	1, 651, 197	35, 08	0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	,				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 647, 086				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	206, 087				2.00
3.00	Total (sum of lines 1-2)	0	1, 853, 173				3.00

Health Financial Systems Laffaye	ette Regional R	Rehabilitation	Hospi	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	1	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
	COM	PUTATION OF RAT		ALLOCATION OF	7/27/2021 8: 18	8 pm
	COM	PUTATION OF RA	1105	ALLUCATION OF	UTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col.			
	1.00	0.00	2)	6.00	5.00	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			00.04	0 00 407 (004	1 00
1.00 CAP REL COSTS-BLDG & FIXT	98, 866		98, 86			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	2, 727, 825		2, 727, 82			2.00
3.00 Total (sum of lines 1-2)	2, 826, 691		2, 826, 69			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FIXT	7, 189	0	7,49	3 229, 153	1, 602, 606	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	198, 352	0	206, 72	B 158, 696	48, 591	2.00
3.00 Total (sum of lines 1-2)	205, 541	0	214, 22	1 387, 849	1, 651, 197	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
				Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FIXT	35, 080	304	7, 18	9 0	1, 874, 332	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	8, 376	198, 35	2 0	414, 015	2.00
3.00 Total (sum of lines 1-2)	35, 080	8, 680	205, 54	1 0	2, 288, 347	3.00
			•			•

Heal th	Financial Systems	Laffayet	te Regional F	Rehabilitation Hospi	In Lie	eu of Form CMS-	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-3042	Period: From 01/01/2020	Worksheet A-8	
					To 12/31/2020		
				Expense Classification o			
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00		1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	C	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
	(chapter 2)		-				
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	C	6.00
7.00	suppliers (chapter 8) Telephone services (pay	А	-1, 343	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
	stations excluded) (chapter					-	
8.00	21) Television and radio service	А	-6, 796	OPERATION OF PLANT	7.00	O	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician	A-8-2	0		0.00	0	1
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	1, 251, 143			0	12.00
	transactions (chapter 10)		1, 201, 110			-	
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -9, 005	DI ETARY	0.00 10.00		
15.00	Rental of quarters to employee and others		0		0.00	C	15.00
16.00	Sale of medical and surgical		0		0.00	C	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than		0		0.00	C	17.00
18.00	patients Sale of medical records and	В	-51	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	0	19.00
17100	education (tuition, fees,		C C		0.00		
20.00	books, etc.) Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	C	21.00
	charges (chapter 21)		_				
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	C	22.00
23 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
23.00	therapy costs in excess of	A-0-3	0	RESFIRATORT ITTERAFT	03.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	C	26.00
27.00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	C	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
	instructions)						
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32 00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	C	32.00
	Depreciation and Interest						
33.00	INTEREST INCOME	В	-143	ADMINISTRATIVE & GENERAL	5.00	0	33.00

Heal th	Fi nan	ici a	I Systems
ADJUST	MENTS	TO	EXPENSES

Laffayette Regional Rehabilitation Hospi

	Financial Systems	Laffaye	tte Regional R	Rehabilitation Hospi	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				eriod:	Worksheet A-8	
					rom 01/01/2020		
					o 12/31/2020	Date/Time Pre 7/27/2021 8:1	pared: 8 nm
				Expense Classification on	Worksheet A	172772021 0.1	
				To/From Which the Amount is			
					····,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MI SC I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00		
33. 11	OTHER	A	-4, /9/	ADMI NI STRATI VE & GENERAL	5.00	0	33. 11
00.40	EXPENSE-ADVERTI SI NG/MARKETI NG-		7 00 4		F 00		00.40
33.13		A	-7,994	ADMINISTRATIVE & GENERAL	5.00	0	33. 13
22.20	EXPENSE-ADVERTI SI NG/MARKETI NG-		100 274		F 00		22.20
33.29	BAD DEBT EXPENSE-BAD DEBT	A		ADMINI STRATI VE & GENERAL	5.00		33. 29 33. 72
33. 72	OTHER EXPENSE-COMMUNITY	A	-2	ADMI NI STRATI VE & GENERAL	5.00	0	33.72
33. 73	OTHER EXPENSE-COMMUNI TY	А	320	ADMI NI STRATI VE & GENERAL	5.00	0	33. 73
55.75	EVENTS	~	520		5.00		55.75
33.82	OTHER EXPENSE-CONTRI BUTI ONS /	А	88	ADMI NI STRATI VE & GENERAL	5.00	0	33, 82
	SPONSO					-	
33.83	OTHER EXPENSE-CONTRI BUTI ONS /	А	-700	ADMI NI STRATI VE & GENERAL	5.00	0	33.83
	SPONSO						
33. 91	OTHER EXPENSE-FLOWERS &	A	-315	ADMI NI STRATI VE & GENERAL	5.00	0	33. 91
	GI FTS						
34.17	TAXES-FRANCHI SE FEES/BUSI NESS	A	- 300	ADMI NI STRATI VE & GENERAL	5.00	0	34.17
	TAX						
34.22	OTHER EXPENSE-GI VEAWAYS	A	-940	ADMINISTRATIVE & GENERAL	5.00	0	34.22
34.24	OTHER EXPENSE-GI VEAWAYS	A		ADMINISTRATIVE & GENERAL	5.00		34.24
34.48	OTHER FEES-LATE FEES	A		ADMINISTRATIVE & GENERAL	5.00	0	34.48
34.65	OTHER FEES-LATE FEES	A		OPERATION OF PLANT	7.00		34.65
34.69	OTHER FEES-LATE FEES	A		DI ETARY	10.00		34.69
34.74	OTHER FEES-LATE FEES	A		MEDICAL RECORDS & LIBRARY	16.00		34.74
34.77	OTHER FEES-LATE FEES	A	-25	MEDICAL SUPPLIES CHARGED TO	71.00	0	34.77
				PATIENTS			
35.23	MARKETING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
35.24	MARKETING BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT			35.24
35.25	TELEPHONE OPERATOR EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		35.25
35.26	TELEPHONE BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT			35.26
35.28	UNALLOWABLE LOBBYING % OF	A	-441	ADMI NI STRATI VE & GENERAL	5.00	0	35. 28
25 22	ASSOC DUES		/		F 00		
35.29	PHYSICIAN CONTRACT	A		ADMINISTRATIVE & GENERAL	5.00	0	35.29
50.00	TOTAL (sum of lines 1 thru 49)		354, 934				50.00
	(Transfer to Worksheet A,						
-	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	Laffayette Regional	Rehabilitation Hospi	In Lieu of Form CMS-2552-10		
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period:	Worksheet A-8	8-1
OFFICE	COSTS			From 01/01/2020 To 12/31/2020		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO Alloc - Cap Rel Bldg	219, 753	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	1, 200	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1, 266, 830	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY MANAGEMENT FEES	0	236, 640	4.00
5.00	0		0	1, 487, 783	236, 640	5.00

* 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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE								

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

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

1 of mout					
6.00	В		0.00 ERNEST HEALTH	100.00	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	FINANCIAL			100.00
	non-financial) specify:				

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Fi nanc	ial Syste	ems			Laffayette Re	egional Reh	abilitatio	n Hos	spi	In Lie	u of Form (CMS-2	552-10
STATEME OFFI CE		COSTS OF	SERVI CES	FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-3042	Period: From 01/01/2020 To 12/31/2020		Prep	bared:
		Net	Wkst. A-7	Ref.								172172021		

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	219, 753	3 9		1.00
2.00	1,200) 9		2.00
3.00	1, 266, 830	0		3.00
4.00	-236, 640	0		4.00
5.00	1, 251, 143	3		5.00

* 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

1105 110	L DEEL POSTED TO MOLKSHEET A,	cordinaris i and/or z, the amount arrowable should be thurcated th cordinaria of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

rerinbu								
6.00	HOME OFFICE	6.00						
7.00		7.00						
8.00		8.00						
9.00		9.00						
10. 00 100. 00		10.00						
100.00		100.00						

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 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.

Director, officer, administrator, or key person of related organization or relative of such person has financial interest in F. provi der.

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F		Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Pre 7/27/2021 8:1	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS			1	_	1	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 874, 332	1, 874, 332		-		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	414,015	7 540	414, 01			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 462, 266 3, 500, 504	7, 540 124, 495			4, 035, 525	4.00 5.00
5.00 7.00	00700 OPERATION OF PLANT	449, 303	431, 058				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	34, 520	431,038		0 0		8.00
9.00	00900 HOUSEKEEPING	167, 543	12, 214				9.00
10.00	01000 DI ETARY	402, 326	172, 015				
13.00	01300 NURSI NG ADMI NI STRATI ON	313, 319	19, 676				•
16.00	01600 MEDICAL RECORDS & LIBRARY	48, 612	20, 422				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 372, 505	764, 875	168, 95	1 528, 651	3, 834, 982	30.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	28, 632	0		0 0		54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	89, 683	0		0 0	89, 683	60.00
65.00		138, 821	7,855				•
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	591, 786 531, 860	132, 506 76, 071	29, 26			
67.00 68.00	06800 SPEECH PATHOLOGY	214, 933	78, 071 8, 640	16, 80 1, 90		274, 482	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	195, 640	18, 065			274, 482	
73.00	07300 DRUGS CHARGED TO PATIENTS	494, 400	21, 993			570, 348	•
74.00	07400 RENAL DIALYSIS	136, 595	21, 773		0 0		
76.00	03950 OTHER ANCI LLARY SERVICE COST CENTERS	137, 554	0		0 0		76.00
	OUTPATIENT SERVICE COST CENTERS		-				
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
91.01	04951 OUTPATI ENT THERAPY	0	0		0 0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0 0		
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	-1	-			-	
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0		117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	13, 599, 149	1, 817, 425	401, 44	5 1, 471, 472	13, 529, 672	118.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	56, 082	12, 38	8 0	68 470	192.00
	07950 MARKETI NG	0	825				192.00
	07951 OTHER NONREI MBURSABLE COST CENTERS	0	020		0 0		194.01
200.00		, i i i i i i i i i i i i i i i i i i i	0		-		200.00
201.00	5		0		o o		201.00
202.00		13, 599, 149	1, 874, 332	414, 01	5 1, 471, 472		

Cost Center Description ADMINISTRATIVE & GRNERAL OPERATION OF 2.00 LINEWISERVICE UNLEXATION OF 8.00 HOUSEKEEPING 0.00 DETERMINE DETERMINE 0.00 1.00 00100 (AP REL COST SENUE & GUIP 4.000 (APREL COSTS-BUDE & FLIXT 2.00 0.00 8.00 9.00 10.00 2.00 00200 (APREL COSTS-BUDE & GUIP 4.000 (APREL COSTS-BUDE & GUIP 5.00 4.035,525 1.404,093 7.00 8.00 9.00 3.00 00000 (LINIXFW & ILINEN SERVICE 1.4,566 1.404,093 7.00 8.00 9.00 11.00 0.00 00000 (DISTARY 9.00 1.00 (SINIX & STRATION 1.00 FERRICE 1.4,566 4.0,03 7.7,428 9.00 10.00 10.00 11.00 6.00 4.0,03 1.7,7,558 1.00 10.00 10.00 10.00 11.00 4.000 4.000 1.177,558 1.00 10.00 10.00 10.00 10.00 11.77,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 1.177,558 <t< th=""><th></th><th></th><th>ette Regional R</th><th></th><th></th><th></th><th>eu of Form CMS-</th><th>2552-10</th></t<>			ette Regional R				eu of Form CMS-	2552-10
Cost Center Description ADMINISTRATIVE & CENERAL SERVICE Cost Center Description ADMINISTRATIVE & CENERAL SERVICE Cost Center Description Display 1.00 Cost Center Description ADMINISTRATIVE & CENERAL SERVICE PLANIN OF LINEN SERVICE LURN SERVICE HUBSREEPINC DISPLAY 1.00 Cost Center Description 5.00 7.00 8.00 9.00 10.00 1.00 Cost Center Description 4.055.525 1.00 0.000 1.000 2.0 1.00 COST OPERATION OF ENTRONCE 1.406.652 1.404.093 4.00 2.0 2.0 1.00 COST OPERATION OF ENTRONCE 1.406.652 1.404.093 4.00 3.17.428 9.00 0.00 COST OPERATION F1.00 1.77.558 1.00 1.0.00	COST A	LLOCATION - GENERAL SERVICE COSIS		Provider C			Worksheet B	
Cost Center Description ADMINISTRATIVE OPERATION OF PLANT LAUNDRY & LINEN SERVICE MOUSEKEEPING DIFARY 100 00100 CAP REL COSTS - BLDG & FIXT								epared:
Berneral PLANT LINEN SERVICE 9.00 10.00 GENERAL SERVICE COST CONTERS 7.00 8.00 9.00 10.00 GENERAL SERVICE COST CONTERS 7.00 7.00 9.00 10.00 0.00 00200 CAP REL COSTS-MUDE FOULP 4 2 2 2 0.00 000500 ADMIN STRATTVE & GENERAL 4,035,525 5 5 5 7.00 0700 OPERATION OF PLANT 416,662 1,404,093 8 5 8.00 000800 ILAUNCY & LINEN SERVICE 14,566 40,086 6 3 9.00 00900 INUSISING ADMINI STRATION 172,372 21,669 44,908 6 1 10.00 01000 INUSSING ADMINI STRATION 172,372 21,669 44,900 1 1 30.00 03000 ADUITS & PEDI ATRICS 1,618,235 819,039 49,066 186,905 1,177,558 3 40.00 4400 SKILLEO NUSSING FACILITY 0 0 0 0 0 6 57.00 05700 CT SCAN 0							7/27/2021 8:1	8 pm
CENERAL SERVICE COST CENTERS 5.00 7.00 8.00 9.00 10.00 00100 (AP REL COSTS-HUBE CONTS-WEDE CONTPANDER OF LODIP 1		Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
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2.00 002000 CAP REL COSTS -MVBLE EQUIP 4 4.00 00400 EMPLOVE BENEFTS DEPRATURENT 4.035,525 7.00 0700 OPERATION OF PLANT 146,662 1,404,093 8.00 0800 LAUNDRY & LINEN SERVICE 14,566 0 49,086 9.00 0900 DUGSEREEN IG 90,315 13,079 0 317,428 9 10.00 01000 DIETARY 282,305 184,196 0 42,033 1,177,558 13 13.00 01600 MEDICAL, RECORDS & LI BRARY 33,995 21,866 0 4,990 0 6 IMPATI ENT ROUTINE SERVICE COST CENTERS 1,618,235 819,039 49,086 186,905 1,177,558 30 44.00 04400 SKILLED NURSI NG FACILITY 0 <td< td=""><td></td><td></td><td>r</td><td></td><td></td><td></td><td></td><td></td></td<>			r					
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202.00 TOTAL (sum lines 118 through 201) 4,035,525 1,404,093 49,086 317,428 1,177,558 202	202.00		4, 035, 525	1, 404, 093	49,08	o 317,428	1,177,558	1202. UU

JST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-3042	Period: From 01/01/2020 To 12/31/2020		
	Cost Center Description	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	TT				I	
00	00100 CAP REL COSTS-BLDG & FIXT						1. (
	00200 CAP REL COSTS-MVBLE EQUIP						2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
00	00500 ADMINISTRATIVE & GENERAL						5.0
00	00700 OPERATION OF PLANT						7.0
00	00800 LAUNDRY & LINEN SERVICE						8.0
	00900 HOUSEKEEPI NG						9. (
	01000 DI ETARY						10.0
	01300 NURSING ADMINISTRATION	606, 747					13. (
5.00	01600 MEDICAL RECORDS & LIBRARY	0	141, 417				16. (
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	606, 747	56, 211	8, 348, 7			
1.00	04400 SKILLED NURSING FACILITY	0	0		0 0) (44.
	ANCI LLARY SERVI CE COST CENTERS	-			1		
	05400 RADI OLOGY-DI AGNOSTI C	0	2, 560	43, 2			
	05700 CT SCAN	0	0		0 0		
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	100.0	0 0		
	06000 LABORATORY	0	5, 813	133, 3			
	06500 RESPI RATORY THERAPY	0	4,066	259, 3			
	06600 PHYSI CAL THERAPY	0	21, 894	1, 451, 8			
	06700 OCCUPATIONAL THERAPY	0	18, 247	1, 178, 5			
	06800 SPEECH PATHOLOGY	0	7, 725	409, 3			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 443	350, 7		000,700	
	07300 DRUGS CHARGED TO PATIENTS	0	17, 414	857, 3			
	07400 RENAL DI ALYSI S	0	2, 205 839	196, 4			
5. 00	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	839	196, 4	30 (196, 436	<u> </u>
. 00	09100 EMERGENCY	0	0		0 0		91.
	04951 OUTPATIENT THERAPY	0	0		0 0		
	04950 OUTPATIENT WOUND CENTER	0	0		0 0) 93.
. 00	OTHER REIMBURSABLE COST CENTERS	0	V		<u> </u>	γ <u></u>	J 7J.
5 00	09500 AMBULANCE SERVICES	0	0		0 0		95.
	10100 HOME HEALTH AGENCY	0	0		0 0		0 101.
	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>			<u>' </u>	
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0		01117.
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	606, 747	141, 417	13, 425, 5	-		
. 5. 00	NONREI MBURSABLE COST CENTERS	000,747	141,417	10, 420, 0		10, 420, 510	
ລາດດ	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	171, 1	19 0	171, 119	102
	07950 MARKETING	0	0	2, 5			7 194.
	07950 MARKETING 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	2, 5	0 0) 194.
0. 00			0				200.
)0.00)1.00	Negative Cost Centers		_) 200.
		1 UI	()				112111

		ette kegronar k			In Lieu		2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2020	Worksheet B Part II	
						Date/Time Pre	pared:
						7/27/2021 8:1	8 pm
			CAPI TAL REL	_ATED COSTS			
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS		-				
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	7, 540	1, 666	9, 206	9, 206	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	124, 495	27, 499	151, 994	2, 396	5.00
7.00	00700 OPERATION OF PLANT	0	431, 058	95, 215	526, 273	74	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900 HOUSEKEEPI NG	0	12, 214	2, 698	14, 912	198	9.00
10.00	01000 DI ETARY	0	172, 015	37, 996	210, 011	355	10.00
	01300 NURSI NG ADMI NI STRATI ON	0	19, 676		24, 022	445	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	20, 422	4, 511	24, 933	44	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		20, 122	1,011	21,700		10.00
30, 00	03000 ADULTS & PEDI ATRI CS	0	764, 875	168, 951	933, 826	3, 308	30.00
	04400 SKILLED NURSING FACILITY	0			000,020	0,000	
44.00	ANCI LLARY SERVICE COST CENTERS	V	0	<u> </u>	0	0	44.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
	06000 LABORATORY	0		0	0	0	60.00
	06500 RESPIRATORY THERAPY	0		1 725	0 500	149	
	06600 PHYSI CAL THERAPY	0	7,855		9, 590		•
		0	132, 506		161, 775	810	
	06700 OCCUPATI ONAL THERAPY	0	76, 071	16, 803	92, 874	756	
	06800 SPEECH PATHOLOGY	0	8, 640		10, 548	307	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18, 065		22, 055	57	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	21, 993	4, 858	26, 851	307	73.00
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS		-		-		
	09100 EMERGENCY	0	0		0	0	91.00
	04951 OUTPATI ENT THERAPY	0	0		0	0	91.01
	04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0			0	0	
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0		-	0	-	117.00
118.00		0	1, 817, 425	401, 445	2, 218, 870	9, 206	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	56, 082	12, 388	68, 470	0	192.00
194.00	07950 MARKETI NG	0	825	182	1, 007	0	194.00
194.01	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00	Cross Foot Adjustments				0	1	200.00
201.00	Negative Cost Centers		0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 874, 332	414, 015	2, 288, 347	9, 206	202.00
	.						

Heal th	Fi na	nci	al	Syste	ems		
		OF	CAL		DEL	ATED	C

	ATION OF CAPITAL RELATED COSTS	ette kegional k	Provi der C	CN: 15-3042 P	eriod: rom 01/01/2020	U OT FORM CMS Worksheet B Part II Date/Time Pre 7/27/2021 8:1	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	÷					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	154, 390					5.00
7.00	00700 OPERATION OF PLANT	15, 940	542, 287				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	557	0	557			8.00
9.00	00900 HOUSEKEEPI NG	3, 455	5, 051	0	23, 616		9.00
10.00	01000 DI ETARY	10, 800	71, 140	0	3, 127	295, 433	10.00
13.00	01300 NURSING ADMINISTRATION	6, 594	8, 137	0	358	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 301	8, 446	0	371	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	61, 914	316, 329	557	13, 905	295, 433	30.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						1
54.00		462	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
60.00		1,448	0	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	2, 781	3, 248	0	143	0	65.00
66.00	06600 PHYSI CAL THERAPY	14, 255	54, 800	0	2, 409	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	12,036	31, 461	0	1, 383	0	67.00
68.00		4, 431	3, 573	0	157	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,662	7, 471	0	328	0	71.00
73.00		9, 207	9, 096	0	400	0	73.00
74.00		2,205	0	0	0	0	74.00
76.00		2, 221	0	0	0	0	•
	OUTPATIENT SERVICE COST CENTERS	· ·					
91.00		0	0	0	0	0	91.00
91.01	04951 OUTPATI ENT THERAPY	0	0	0	0	0	91.01
93.00		0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
101.0	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	·					1
117.0	0 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.0	0 SUBTOTALS (SUM OF LINES 1 through 117)	153, 269	518, 752	557	22, 581	295, 433	118.00
	NONREI MBURSABLE COST CENTERS						1
192.0	0 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 105	23, 194	0	1, 020	0	192.00
194.0	0 07950 MARKETI NG	16	341	0	15	0	194.00
194.0	1 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.0							200.00
201.0	5	0	0	0	0	0	201.00
202.0	0 TOTAL (sum lines 118 through 201)	154, 390	542, 287	557	23, 616	295, 433	202.00
					•		

Heal th	Financial Systems Laffaye	ette Regional Re	ehabilitation	Hospi	In Lie	eu of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-3042	Peri od:	Worksheet B	
					From 01/01/2020		
					To 12/31/2020		epared:
	Cont Conton Dependention			Cultated	Listers 0	7/27/2021 8:1	18 pm
	Cost Center Description	NURSI NG	MEDICAL	Subtotal	Intern &	Total	
		ADMI NI STRATI ON	RECORDS &		Residents Cost		
			LI BRARY		& Post		
					Stepdown		
					Adj ustments		
		13.00	16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	1		1		1	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG			1			9.00
10.00	01000 DI ETARY						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	39, 556					13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	35, 095				16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	00,070	I		1	10.00
30, 00	03000 ADULTS & PEDI ATRI CS	39, 556	13, 954	1, 678, 7	82 0	1, 678, 782	30,00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0,000	13, 734	1,070,7	0 0		
44.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		0 0		44.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	635	1, 0	97 0	1, 097	54.00
57.00		0	035	1,0			
	05700 CT SCAN	0	0		0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	-	
60.00	06000 LABORATORY	0	1, 442	2, 8			
65.00	06500 RESPI RATORY THERAPY	0	1,009			10,720	
66.00	06600 PHYSI CAL THERAPY	0	5, 432			2077 101	
67.00	06700 OCCUPATI ONAL THERAPY	0	4, 527	143, 0		1.10,007	
68.00	06800 SPEECH PATHOLOGY	0	1, 917	20, 9	33 0	20, 933	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 103	34, 6	76 0	34, 676	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 321	50, 1	82 0	50, 182	73.00
74.00	07400 RENAL DIALYSIS	0	547	2, 7	52 0	2, 752	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	208	2, 4	29 0	2, 429	76.00
	OUTPATIENT SERVICE COST CENTERS				·	-	
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
	04951 OUTPATI ENT THERAPY	0	0		0 0	0	91.01
	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS	· · · · ·		I			
95.00	09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
	10100 HOME HEALTH AGENCY	0	0		0 0		101.00
101100	SPECIAL PURPOSE COST CENTERS						
117 00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	C	117.00
118.00		39, 556	35, 095				
110.00	NONREI MBURSABLE COST CENTERS	37, 330	33, 073	2,173,1	,,,	2,175,177	1110.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	93, 7	89 0	03 780	192.00
	07950 MARKETI NG	0	0	1, 3			192.00
			0	1, 3			
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.01
200.00			_		0		200.00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	39, 556	35, 095	2, 288, 3	47 0	2, 288, 347	202.00

In Lieu of Form CMS-2552-10

		ette Regional R			In Lie	u of Form CMS-:	
COST AL	LOCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	narod
				1	0 12/31/2020	7/27/2021 8:1	aneu: 8 nm
		CAPI TAL REL	ATED COSTS			1112112021 0.1	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
		. ,		DEPARTMENT		(ACCUM. COST)	
				(GROSS		, , ,	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	47, 726					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		47, 726				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	192	192	5, 970, 423	6		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 170	3, 170	1, 554, 113	-4, 035, 525	9, 563, 624	5.00
7.00	00700 OPERATION OF PLANT	10, 976	10, 976	48, 100	0	987, 431	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	c c	0 0	34, 520	8.00
9.00	00900 HOUSEKEEPI NG	311	311	128, 130	0	214, 034	9.00
10.00	01000 DI ETARY	4, 380	4, 380	230, 005	0	669, 024	10.00
13.00	01300 NURSING ADMINISTRATION	501	501				
	01600 MEDI CAL RECORDS & LI BRARY	520	520				
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	19, 476	19, 476	2, 144, 977	0	3, 834, 982	30.00
	04400 SKI LLED NURSI NG FACI LI TY	0	0				
	ANCI LLARY SERVICE COST CENTERS	-		-	-		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C) 0	28, 632	54.00
	05700 CT SCAN	0	0		-		
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		-		
	06000 LABORATORY	0	0		-		
	06500 RESPI RATORY THERAPY	200	200	, s			
	06600 PHYSI CAL THERAPY	3, 374	3, 374			883, 059	
	06700 OCCUPATIONAL THERAPY	1, 937	1, 937				
	06800 SPEECH PATHOLOGY	220	220			274, 482	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	460	460				
	07300 DRUGS CHARGED TO PATIENTS	560	560				
	07400 RENAL DIALYSIS	0	0				
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				
	OUTPATIENT SERVICE COST CENTERS	0	0		, 0	137, 334	70.00
	09100 EMERGENCY	0	0	C	0	0	91.00
	04951 OUTPATIENT THERAPY				-	-	
		0	0		-		
	04950 OUTPATIENT WOUND CENTER	0	0	C	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS	0	0				05 00
	09500 AMBULANCE SERVICES	0					
-	10100 HOME HEALTH AGENCY	0	0	C	0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						117 00
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0				117.00
118.00		46, 277	46, 277	5, 970, 423	-4, 035, 525	9, 494, 147	118.00
	NONREI MBURSABLE COST CENTERS	4 400	1 400			(0.470	100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 428					192.00
	07950 MARKETING	21	21				194.00
	07951 OTHER NONREI MBURSABLE COST CENTERS	0	0	C	0 0	0	194.01
200.00							200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	1, 874, 332	414, 015	1, 471, 472		4, 035, 525	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	39. 272765	8. 674831			0. 421966	
204.00				9, 206		154, 390	204.00
	Part II)					1	
205.00	Unit cost multiplier (Wkst. B, Part			0. 001542	2	0. 016143	205.00
	11)						
206.00	NAHE adjustment amount to be allocated					l	206.00
	(per Wkst. B-2)					1	
207.00						l	207.00
	Parts III and IV)			l		1	1

Heal th	Fi nanci al	Systems	
COST A			D

	*	yette kegronar k				Wardung Portin CMS	
JUST A	LLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		narod
					10 12/31/2020	7/27/2021 8:1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	oust center beschiption	PLANT	LINEN SERVICE		(TOTAL PATI ENT		il i
			(TOTAL PATIENT	· · · · · · · · · · · · · · · · · · ·	DAYS)		
		(SQUARE FEET)			DATS)	(NURSI NG	
			DAYS)				
		7.00			10.00	SALARI ES)	
		7.00	8.00	9.00	10.00	13.00	
	GENERAL SERVICE COST CENTERS		1		1		-
1.00	00100 CAP REL COSTS-BLDG & FIXT					1	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					ĺ	2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					ĺ	4.0
5.00	00500 ADMINISTRATIVE & GENERAL						5.0
7.00	00700 OPERATION OF PLANT	33, 388				Í	7.0
3. 00	00800 LAUNDRY & LINEN SERVICE	0				Í	8.0
9.00	00900 HOUSEKEEPI NG	311			7		9.0
	01000 DI ETARY						10.0
		4, 380					
	01300 NURSING ADMINISTRATION	501					
6.00	01600 MEDI CAL RECORDS & LI BRARY	520	0	52	0 0	0	16.0
	INPATIENT ROUTINE SERVICE COST CENTERS		1		1		
30.00	03000 ADULTS & PEDI ATRI CS	19, 476	7, 431	19, 47	6 7,431	2, 144, 977	30.0
14.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.0
	ANCI LLARY SERVICE COST CENTERS						1
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.0
	05700 CT SCAN	0			0 0	-	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		-		0 0		
		0	0		-		
0.00	06000 LABORATORY	0	0		0 0	0	
5.00	06500 RESPI RATORY THERAPY	200				-	
6.00	06600 PHYSI CAL THERAPY	3, 374	0	3, 37	4 0	0	
57.00	06700 OCCUPATI ONAL THERAPY	1, 937	0	1, 93	7 0	0	67.0
68.00	06800 SPEECH PATHOLOGY	220	0	22	0 0	0	68.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	460	0	46	0 0	0	71.0
	07300 DRUGS CHARGED TO PATIENTS	560	0	56	0 0	0	73.0
	07400 RENAL DI ALYSI S	0			0 0	-	
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0		
	OUTPATIENT SERVICE COST CENTERS		ή 0		0 0		- /0.0
	09100 EMERGENCY	0	0		0 0	0	91.0
	04951 OUTPATIENT THERAPY	0			0 0		
	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93.0
	OTHER REIMBURSABLE COST CENTERS		T		- 1		
95.00	09500 AMBULANCE SERVICES	0	0		0 0	0	95.0
01.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.0
	SPECIAL PURPOSE COST CENTERS						1
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	117.0
18.00							
	NONREI MBURSABLE COST CENTERS	/ 51, 939	1, 401	51,02	7,431	2, 177, 777	1.10.0
	19200 PHYSICIANS' PRIVATE OFFICES	1 400		1 40	0		102 0
		1, 428					192.0
	07950 MARKETI NG	21					194.0
	07951 OTHER NONREI MBURSABLE COST CENTERS	0	0 0		0 0	0) 194. C
00.00	Cross Foot Adjustments					1	200.0
01.00	Negative Cost Centers					1	201.0
02.00		1, 404, 093	49, 086	317, 42	8 1, 177, 558	606, 747	
	Part I)						1
03.00) 42.053822	6. 605571	9. 59663	8 158. 465617	0. 282869	203 0
204.00		542, 287					
.04.00	Part II)	542,207	557	23,01	270,433	37, 330	204.0
	-	1/ 0/1070	0.074054	0 71007		0.010444	005 0
205.00		16. 241973	0. 074956	0. 71397	0 39. 756829	0. 018441	205.0
						1	00/ -
206.00		d				1	206. 0
	(per Wkst. B-2)					1	
							1007 0
207.00							207.0

ealth Financial Systems La	affayette Regional R	enapilitation Hospi	In Lieu	」of Form CMS-2552
OST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-3042	Peri od:	Worksheet B-1
			From 01/01/2020 To 12/31/2020	Date/Time Prepare
				7/27/2021 8:18 pr
Cost Center Description	MEDICAL			
	RECORDS &			
	LI BRARY			
	(GROSS			
	CHARGES)			
	16.00			
GENERAL SERVICE COST CENTERS				
00 00100 CAP REL COSTS-BLDG & FIXT				1
00 00200 CAP REL COSTS-MVBLE EQUIP				2
. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4
00 00500 ADMINISTRATIVE & GENERAL				5
00 00700 OPERATION OF PLANT				7
00 00800 LAUNDRY & LINEN SERVICE				8
00 00900 HOUSEKEEPING				9
0. 00 01000 DI ETARY				10
8. 00 01300 NURSING ADMINISTRATION				13
0. 00 01600 MEDICAL RECORDS & LIBRARY	16, 829, 588			16
INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00 03000 ADULTS & PEDIATRICS	6, 689, 700			30
. 00 04400 SKILLED NURSING FACILITY	0			44
ANCILLARY SERVICE COST CENTERS				
. 00 05400 RADI OLOGY-DI AGNOSTI C	304, 657			54
. 00 05700 CT SCAN	0			57
	0			
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58
. 00 06000 LABORATORY	691, 774			60
. 00 06500 RESPI RATORY THERAPY	483, 821			65
00 06600 PHYSI CAL THERAPY	2, 605, 460			66
2.00 06700 OCCUPATI ONAL THERAPY	2, 171, 444			67
. 00 06800 SPEECH PATHOLOGY	919, 329			68
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				71
8. 00 07300 DRUGS CHARGED TO PATIENTS	2,072,316			73
. 00 07400 RENAL DIALYSIS	262, 450			74
. 00 03950 OTHER ANCILLARY SERVICE COST CENTE	RS 99, 839			76
OUTPATIENT SERVICE COST CENTERS				
. 00 09100 EMERGENCY	0			91
. 01 04951 OUTPATIENT THERAPY	0			91
. 00 04950 OUTPATIENT WOUND CENTER	0			93
OTHER REIMBURSABLE COST CENTERS				
00 09500 AMBULANCE SERVICES	0			95
1.00 10100 HOME HEALTH AGENCY	0			101
SPECIAL PURPOSE COST CENTERS				
7. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0			117
8.00 SUBTOTALS (SUM OF LINES 1 through				118
NONREI MBURSABLE COST CENTERS	, 10, 027, 300			
2. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192
				192
4. 00 07950 MARKETING	0			
4.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0			194
0.00 Cross Foot Adjustments				200
1.00 Negative Cost Centers				201
2.00 Cost to be allocated (per Wkst. B,	141, 417			202
Part I)				[
3.00 Unit cost multiplier (Wkst. B, Par	t I) 0.008403			203
4.00 Cost to be allocated (per Wkst. B,	35, 095			200
Part II)	33, 095			204
				005
	t 0. 002085			205
)(00 NAUE adjustment amount to be allos	atad			
06.00 NAHE adjustment amount to be alloc	ated			206
(per Wkst. B-2)				
07.00 NAHE unit cost multiplier (Wkst. D),			207
Parts III and IV)	1			

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-3042	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre	
			Ti ti o	• XVIII	Hospi tal	7/27/2021 8:1 PPS	8 pm
			in the		Costs	ГГЈ	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 348, 763		8, 348, 70	53 0	8, 348, 763	30.00
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	43, 274		43, 2	74 0	43, 274	54.00
57.00	05700 CT SCAN	0			0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
60.00	06000 LABORATORY	133, 339		133, 33	39 0	133, 339	60.00
65.00	06500 RESPI RATORY THERAPY	259, 391	0	259, 39	91 0	259, 391	65.00
66.00	06600 PHYSI CAL THERAPY	1, 451, 843	0	1, 451, 84	43 0	1, 451, 843	66.00
67.00	06700 OCCUPATIONAL THERAPY	1, 178, 529	0	1, 178, 52	29 0	1, 178, 529	67.00
68.00	06800 SPEECH PATHOLOGY	409, 392	0	409, 39	92 0	409, 392	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	350, 755		350, 75	55 0	350, 755	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	857, 353		857, 3	53 0	857, 353	73.00
74.00	07400 RENAL DIALYSIS	196, 438		196, 43	38 0	196, 438	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	196, 436		196, 43	36 0	196, 436	76.00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0			0 0	0	91.00
	04951 OUTPATI ENT THERAPY	0			0 0	0	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0			0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0			0 0	0	95.00
101.00	10100 HOME HEALTH AGENCY	0			0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0			0		117.00
200.00		13, 425, 513	0	13, 425, 51	13 0	13, 425, 513	
201.00		0			0		201.00
202.00	Total (see instructions)	13, 425, 513	0	13, 425, 5	13 0	13, 425, 513	202.00

	yette Regional Re			In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/27/2021 8:1	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 689, 700		6, 689, 70	0		30.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	304, 657	0	304, 65		0. 000000	
57.00 05700 CT SCAN	0	0		0 0.000000	0.000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0. 000000	0.00000	
60. 00 06000 LABORATORY	691, 774	0	691, 77		0.00000	
65. 00 06500 RESPI RATORY THERAPY	483, 821	0	483, 82		0.00000	
66. 00 06600 PHYSI CAL THERAPY	1, 989, 130	616, 330			0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 874, 015	297, 429	2, 171, 44		0.00000	
68. 00 06800 SPEECH PATHOLOGY	771, 625	147, 704	919, 32		0.00000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	528, 798	0	528, 79		0.00000	•
73.00 07300 DRUGS CHARGED TO PATIENTS	2,072,316	0	2, 072, 31		0.000000	
74.00 07400 RENAL DI ALYSI S	262, 450	0	262, 45		0.000000	
76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	99, 839	0	99, 83	9 1.967528	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS				0 000000	0.000000	0.1 0.0
91. 00 09100 EMERGENCY	0	0		0 0. 000000	0.000000	
91. 01 04951 OUTPATIENT THERAPY	0	0		0 0. 000000	0.000000	
93. 00 04950 OUTPATIENT WOUND CENTER OTHER REIMBURSABLE COST CENTERS	0	0		0 0.00000	0.000000	93.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0.00000	0. 000000	95.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0.000000	0.000000	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0		0		101.00
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0		117.00
200.00 Subtotal (see instructions)	15, 768, 125	1,061,463		-		200.00
201.00 Less Observation Beds	13,700,123	1,001,403	10, 02 9, 00			200.00
202.00 Total (see instructions)	15, 768, 125	1,061,463	16, 829, 58	8		201.00

In Lieu of Form CMS-2552-10

near th		ette kegionai ken				-2332-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3042	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pr 7/27/2021 8:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient			L	
	•	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
44.00	04400 SKILLED NURSING FACILITY					44.00
	ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 142042				54.00
57.00	05700 CT SCAN	0. 000000				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
60.00	06000 LABORATORY	0. 192749				60.00
65.00	06500 RESPI RATORY THERAPY	0. 536130				65.00
66.00	06600 PHYSI CAL THERAPY	0. 557231				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 542740				67.00
68.00	06800 SPEECH PATHOLOGY	0. 445316				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 663306				71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 413717				73.00
74.00	07400 RENAL DIALYSIS	0. 748478				74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	1. 967528				76.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0. 000000				91.00
91.01	04951 OUTPATI ENT THERAPY	0. 000000				91.01
93.00	04950 OUTPATIENT WOUND CENTER	0. 000000				93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 000000				95.00
101.00	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS					117.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/27/2021 8:1	
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	8, 348, 763		8, 348, 76		8, 348, 763	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS	40.074		40.0		40.074	54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	43, 274		43, 27	4 0	43, 274	54.00
57.00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY	122.220		100.00	0 0	122.220	58.00 60.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	133, 339	0	133, 33		133, 339 259, 391	65.00
66. 00 06600 PHYSI CAL THERAPY	259, 391 1, 451, 843	0	259, 39 1, 451, 84		259, 391	
67. 00 06700 OCCUPATIONAL THERAPY	1, 178, 529	0	1, 178, 52		1, 431, 843	
68. 00 06800 SPEECH PATHOLOGY	409, 392	0	409, 39		409, 392	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	350, 755	0	350, 75		350, 755	
73. 00 07300 DRUGS CHARGED TO PATIENTS	857, 353		857, 35		857, 353	
74. 00 07400 RENAL DI ALYSI S	196, 438		196, 43		196, 438	
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	196, 436		196, 43		196, 436	
OUTPATIENT SERVICE COST CENTERS	170,430		170,40	0 0	170, 430	70.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
91. 01 04951 OUTPATIENT THERAPY	0			0 0	0	91.01
93. 00 04950 OUTPATIENT WOUND CENTER	0			0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS			•			
117.0006950 OTHER SPECIAL PURPOSE COST CENTERS	0			0	0	117.00
200.00 Subtotal (see instructions)	13, 425, 513	0	13, 425, 51	3 0	13, 425, 513	200. 00
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	13, 425, 513	0	13, 425, 51	3 0	13, 425, 513	202.00

		ette Regional Re				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2020	Worksheet C Part I	
					To 12/31/2020	Date/Time Pre	pared:
						7/27/2021 8:1	8 pm
				e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6.00	7.00	8.00	9,00	Rati o 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
30, 00	03000 ADULTS & PEDIATRICS	6, 689, 700		6, 689, 70	0		30.00
44.00	04400 SKILLED NURSING FACILITY	0,089,700		0,009,70	0		44.00
44.00	ANCI LLARY SERVICE COST CENTERS				0		44.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	304, 657	0	304, 65	0, 142042	0.00000	54.00
57.00	05700 CT SCAN	504,057	0	504, 00	0. 000000	0.000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.000000	
60.00	06000 LABORATORY	691, 774	0	691, 77		0.000000	
65.00	06500 RESPI RATORY THERAPY	483, 821	0	483, 82		0.000000	
66.00	06600 PHYSI CAL THERAPY	1, 989, 130	616, 330			0, 000000	
67.00	06700 OCCUPATI ONAL THERAPY	1, 874, 015	297, 429			0. 000000	
68.00	06800 SPEECH PATHOLOGY	771, 625	147, 704			0. 000000	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	528, 798	0	528, 79		0.000000	•
73.00	07300 DRUGS CHARGED TO PATIENTS	2,072,316	0	2, 072, 31	6 0.413717	0.000000	73.00
74.00	07400 RENAL DIALYSIS	262, 450	0	262, 45	0 0.748478	0.000000	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	99, 839	0	99, 83	9 1.967528	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	0		0 0.000000	0.000000	91.00
91.01	04951 OUTPATI ENT THERAPY	0	0		0 0.000000	0.000000	91.01
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0.000000	0.00000	93.00
	OTHER REIMBURSABLE COST CENTERS				-		
	09500 AMBULANCE SERVICES	0	0		0 0.000000	0. 000000	
101.00	10100 HOME HEALTH AGENCY	0	0		0		101.00
	SPECIAL PURPOSE COST CENTERS						-
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0		117.00
200.00		15, 768, 125	1,061,463	16, 829, 58	8		200.00
201.00					_		201.00
202.00	Total (see instructions)	15, 768, 125	1, 061, 463	16, 829, 58	8		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/27/2021 8:	epared: 18 pm
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	- I I				
30. 00 03000 ADULTS & PEDIATRICS					30.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCI LLARY SERVI CE COST CENTERS					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 142042				54.00
57.00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
60. 00 06000 LABORATORY	0. 192749				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 536130				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 557231				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 542740				67.00
68.00 06800 SPEECH PATHOLOGY	0. 445316				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 663306				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 413717				73.00
74.00 07400 RENAL DI ALYSI S	0. 748478				74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	1.967528				76.00
OUTPATIENT SERVICE COST CENTERS	- i				
91.00 09100 EMERGENCY	0. 000000				91.00
91. 01 04951 OUTPATI ENT THERAPY	0. 000000				91.01
93.00 04950 OUTPATIENT WOUND CENTER	0. 000000				93.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
117.0006950 OTHER SPECIAL PURPOSE COST CENTERS					117.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems Laffayette Regional Rehabilitation Hospi In Lieu of Form CMS-2552-10								
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA		Provider C	CN: 15-3042	Peri od:	Worksheet C			
REDUCTIONS FOR MEDICALD ONLY				From 01/01/2020 To 12/31/2020		norod.		
				To 12/31/2020	Date/Time Pre 7/27/2021 8:1			
			e XIX	Hospi tal	PPS			
Cost Center Description	Total Cost	Capital Cost			Operating Cost			
	(Wkst. B, Part				Reduction			
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount			
			col. 2)					
	1.00	2.00	3.00	4.00	5.00			
ANCI LLARY SERVI CE COST CENTERS	I		1 .	1				
54.00 05400 RADI OLOGY-DI AGNOSTI C	43, 274	1, 097	42, 17	7 0	0	54.00		
57.00 05700 CT SCAN	0	C)	0 0	0	57.00		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0 0	0	58.00		
60. 00 06000 LABORATORY	133, 339	2, 890			0	60.00		
65. 00 06500 RESPI RATORY THERAPY	259, 391	16, 920			0	65.00		
66. 00 06600 PHYSI CAL THERAPY	1, 451, 843				0	66.00		
67.00 06700 OCCUPATI ONAL THERAPY	1, 178, 529				0	67.00		
68.00 06800 SPEECH PATHOLOGY	409, 392	20, 933			0	68.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	350, 755			9 0	0	71.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	857, 353	50, 182			0	73.00		
74. 00 07400 RENAL DI ALYSI S	196, 438	2, 752	193, 68	6 0	0	74.00		
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	196, 436	2, 429	194, 00	7 0	0	76.00		
OUTPATIENT SERVICE COST CENTERS								
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00		
91. 01 04951 OUTPATI ENT THERAPY	0	C		0 0	0	91.01		
93.00 04950 OUTPATIENT WOUND CENTER	0	C)	0 0	0	93.00		
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVICES	0	C)	0 0	0	95.00		
101.00 10100 HOME HEALTH AGENCY	0	C)	0 0	0	101.00		
SPECIAL PURPOSE COST CENTERS								
117.00069500THER SPECIAL PURPOSE COST CENTERS	0	C)	0 0	0	117.00		
200.00 Subtotal (sum of lines 50 thru 199)	5, 076, 750	514, 397	4, 562, 35	3 0		200. 00		
201.00 Less Observation Beds	0	C		0 0	0	201.00		
202.00 Total (line 200 minus line 201)	5, 076, 750	514, 397	4, 562, 35	3 0	0	202.00		

Health Financial Systems Laffay	ette Regional R	ehabilitation	Hospi	In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/27/2021 8:2	
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
	Capital and	(Worksheet C,				
	Operating Cost			6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS			1			_
54.00 05400 RADI OLOGY-DI AGNOSTI C	43, 274	304, 657				54.00
57.00 05700 CT SCAN	0	0	0.0000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	00		58.00
60. 00 06000 LABORATORY	133, 339	691, 774	0. 19274	19		60.00
65. 00 06500 RESPI RATORY THERAPY	259, 391	483, 821	0. 53613	30		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 451, 843	2, 605, 460	0. 55723	31		66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 178, 529	2, 171, 444	0. 54274	łO		67.00
68.00 06800 SPEECH PATHOLOGY	409, 392	919, 329	0. 44531	6		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	350, 755	528, 798	0. 66330	06		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	857, 353	2, 072, 316	0. 4137	7		73.00
74.00 07400 RENAL DIALYSIS	196, 438	262, 450	0. 74847	8		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	196, 436	99, 839	1.96752	28		76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0.0000	00		91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0	0.0000	00		91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0.0000	00		93.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
95. 00 09500 AMBULANCE SERVICES	0	0	0.0000	00		95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0.0000	00		101.00
SPECIAL PURPOSE COST CENTERS						
117.0006950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.0000	00		117.00
200.00 Subtotal (sum of lines 50 thru 199)	5, 076, 750	10, 139, 888				200.00
201.00 Less Observation Beds	0	0				201.00
202.00 Total (line 200 minus line 201)	5, 076, 750	10, 139, 888				202.00

Health Financial Systems Laffayette Regional Rehabilitation Hospi In Lieu of Form CMS-2							
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D		
				From 01/01/2020 To 12/31/2020		pared:	
					7/27/2021 8:1	8 pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1.00	2.00	3.00	4.00	5.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T	-	-	- F			
30. 00 ADULTS & PEDIATRICS	1, 678, 782	0	1, 678, 78	2 7, 431	225.92	30.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00	
200.00 Total (lines 30 through 199)	1, 678, 782		1, 678, 78	2 7, 431		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	4, 658	1, 052, 335	i i			30.00	
44.00 SKILLED NURSING FACILITY	0	0				44.00	
200.00 Total (lines 30 through 199)	4, 658	1, 052, 335	5			200. 00	

Health Financial Systems Laffaye	ette Regional R	ehabilitation	Hospi	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1	-	1	1		
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 097	304, 657			739	
57.00 05700 CT SCAN	0	0	0.00000	0 0	0	07100
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000		0	58.00
60. 00 06000 LABORATORY	2, 890		0. 00417			60.00
65. 00 06500 RESPI RATORY THERAPY	16, 920	483, 821	0. 03497	2 308, 828	10, 800	65.00
66. 00 06600 PHYSI CAL THERAPY	239, 481	2, 605, 460	0. 09191	5 1, 242, 085	114, 166	66.00
67.00 06700 OCCUPATIONAL THERAPY	143, 037	2, 171, 444	0. 06587	2 1, 188, 915	78, 316	67.00
68.00 06800 SPEECH PATHOLOGY	20, 933	919, 329	0. 02277	0 499, 410	11, 372	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 676	528, 798	0. 06557	5 295, 150	19, 354	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	50, 182	2, 072, 316	0. 02421	5 1, 294, 669	31, 350	73.00
74.00 07400 RENAL DIALYSIS	2, 752	262, 450	0. 01048	6 122, 650	1, 286	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	2, 429	99, 839	0. 02432	9 66, 849	1, 626	76.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0	0	0.00000	0 0	0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0	0.00000	0 0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0.00000	0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		•				1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	514, 397	10, 139, 888		5, 744, 545	271, 184	200. 00

	affayette Regional Re				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COST			Period: From 01/01/2020 To 12/31/2020		epared: 8 pm
		Title	XVIII	Hospi tal	PPS	-
Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	0		o o	l o	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	Per Diem (col.	Inpati ent	
···· Free Press	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		í í		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	7,43	1 0.00	4, 658	30.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44.00
200.00 Total (lines 30 through 199)		0	7,43			200.00
Cost Center Description	I npati ent					
···· Free Press	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	-					200.00

Heal th	Health Financial Systems Laffayette Regional Rehabilitation Hospi In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV THROUGH COSTS		VICE OTHER PAS	S Provider C		Period: From 01/01/2020 To 12/31/2020				
			Title	2 XVIII	Hospi tal	PPS			
	Cost Center Description		Nursing School	Nursing Schoo	Allied Health	Allied Health			
			Post-Stepdown		Post-Stepdown				
		Cost	Adjustments		Adjustments				
		1.00	2A	2.00	3A	3.00			
F 4 00	ANCI LLARY SERVICE COST CENTERS				0		54.00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00		
57.00	05700 CT SCAN	0	0		0 0	0	57.00		
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00		
60.00	06000 LABORATORY	0	0		0 0	0	60.00		
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00		
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00		
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00		
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00		
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00		
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0)	0 0	0	76.00		
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0	0)	0 0	0	91.00		
91.01	04951 OUTPATI ENT THERAPY	0	0		0 0	0	91.01		
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0	93.00		
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVI CES						95.00		
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00		

Health Financial Systems Laffay	ette Regional R	ehabilitation	Hospi	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	
					7/27/2021 8:1	8 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 304, 657	0. 000000	54.00
57.00 05700 CT SCAN	0	0		0 0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	58.00
60. 00 06000 LABORATORY	0	0		0 691, 774	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 483, 821	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 605, 460	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 171, 444	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 919, 329	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 528, 798	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 072, 316	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 262, 450		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 99,839		76.00
OUTPATIENT SERVICE COST CENTERS			1			
91.00 09100 EMERGENCY	0	0		0 0	0,00000	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0		0 0	0.000000	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0		0 0	0. 000000	•
OTHER REIMBURSABLE COST CENTERS				<u> </u>		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 10, 139, 888		200.00
		-			1	

Health Financial Systems Laffayette Regional Rehabilitation Hospi In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2020 To 12/31/2020		pared: 8 pm		
		Title	XVIII	Hospi tal	PPS			
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent			
	Ratio of Cost	Program	Program	Program	Program			
	to Charges	Charges	Pass-Through		Pass-Through			
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9			
	7)		x col. 10)		x col. 12)			
	9.00	10.00	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS				- F	-			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	205, 330		0 0	0	54.00		
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00		
60. 00 06000 LABORATORY	0. 000000	520, 659		0 0	0	60.00		
65. 00 06500 RESPI RATORY THERAPY	0. 000000	308, 828		0 0	0	65.00		
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 242, 085		0 0	0	66.00		
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 188, 915		0 0	0	67.00		
68.00 06800 SPEECH PATHOLOGY	0. 000000	499, 410		0 0	0	68.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	295, 150		0 0	0	71.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 294, 669		0 0	0	73.00		
74.00 07400 RENAL DIALYSIS	0. 000000	122, 650		0 0	0	74.00		
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	66, 849		0 0	0	76.00		
OUTPATIENT SERVICE COST CENTERS								
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00		
91. 01 04951 OUTPATI ENT THERAPY	0. 000000	0		0 0	0	91.01		
93.00 04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	0	93.00		
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVICES						95.00		
200.00 Total (lines 50 through 199)		5, 744, 545		0 0	0	200. 00		

Health Fir	nancial Systems Laffay	ette Regional R	ehabilitation	Hospi	In Lie	u of Form CMS-	2552-10
APPORTI ON	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-3042	Period: From 01/01/2020 To 12/31/2020		
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS	1					
	400 RADI OLOGY-DI AGNOSTI C	0. 142042			0 0	0	
	700 CT SCAN	0. 000000			0 0	0	
58.00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60.00 060	DOO LABORATORY	0. 192749	0		0 0	0	60.00
65.00 065	500 RESPI RATORY THERAPY	0. 536130	0		0 0	0	65.00
66.00 066	500 PHYSI CAL THERAPY	0. 557231	0		0 0	0	66.00
67.00 067	700 OCCUPATI ONAL THERAPY	0. 542740	0		0 0	0	67.00
68.00 068	BOO SPEECH PATHOLOGY	0. 445316	0		0 0	0	68.00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663306	0		0 0	0	71.00
73.00 073	300 DRUGS CHARGED TO PATIENTS	0. 413717	l o		0 0	0	73.00
74.00 074	400 RENAL DIALYSIS	0. 748478	0		0 0	0	74.00
76.00 039	950 OTHER ANCILLARY SERVICE COST CENTERS	1.967528	0		0 0	0	76.00
	IPATIENT SERVICE COST CENTERS			1	·	`	
	100 EMERGENCY	0. 000000	0		0 0	0	91.00
	751 OUTPATIENT THERAPY	0. 000000			0 0	0	
	950 OUTPATIENT WOUND CENTER	0. 000000			0 0	0	
	HER REIMBURSABLE COST CENTERS	0.000000	<u> </u>	1	<u> </u>	Ŭ	1 101 00
	500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00	Subtotal (see instructions)	5.000000	n –		0 0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program		Ĭ		0 0	0	201.00
201.00	Only Charges						201.00
202.00	Net Charges (line 200 - line 201)		o		0 0	0	202.00

Health Financial Systems L	affayette Regional F	Rehabilitation	Hospi	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	ES AND VACCINE COST	Provider C		Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/27/2021 8:	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		1				_
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700 CT SCAN	0	0 0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0 0				58.00
60. 00 06000 LABORATORY	0	0 0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS O	0				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENT	ERS 0	0				76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0				91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0				91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0				93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Pro	gram O					201.00
Only Charges	-					
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems Laffayette Regional Rehabilitation Hospi In Lieu of Form CMS-25						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2020 To 12/31/2020		pared: 8 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 678, 782	0	1, 678, 78	2 7, 431	225.92	30.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30 through 199)	1, 678, 782		1, 678, 78	2 7, 431		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	191	43, 151				30.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	191	43, 151				200. 00

Health Financial Systems Laffaye	ette Regional R	ehabilitation	Hospi	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-3042	Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	narod
				10 12/31/2020	7/27/2021 8:1	
		Titl	e XIX	Hospi tal	PPS	_
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	I	1	1		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 097	304, 657			0	
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000		0	58.00
60. 00 06000 LABORATORY	2, 890				0	60.00
65. 00 06500 RESPI RATORY THERAPY	16, 920				0	65.00
66. 00 06600 PHYSI CAL THERAPY	239, 481				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	143, 037			-	0	67.00
68.00 06800 SPEECH PATHOLOGY	20, 933	919, 329	0. 0227	70 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 676	528, 798	0.0655	75 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	50, 182				0	73.00
74. 00 07400 RENAL DI ALYSI S	2, 752	262, 450	0. 01048	36 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	2, 429	99, 839	0. 02432	29 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	0.0000	0 00	0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0	0.0000		0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0	0.0000	0 00	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	514, 397	10, 139, 888		0	0	200.00

Health Financial Systems	Laffayette Regional R	ehabilitation	Hospi	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	E OTHER PASS THROUGH COST			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/27/2021 8:1	epared: 8 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments		Post-Stepdowr Adjustments		Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDI ATRI CS 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0 0		0 0 0 0	0	44.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30.00 03000 ADULTS & PEDIATRICS 44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0	0 0 0	7, 43	0 0.00	0	
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		,,,,,	•		200.00
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30.00 03000 ADULTS & PEDIATRICS 44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0 0 0					30.00 44.00 200.00

Health Financial Systems Laffay	ette Regional R	ehabilitation	Hospi	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2020 To 12/31/2020		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School Post-Stepdown Adjustments		I Allied Health Post-Stepdown Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS					•	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0 0	0	58.00
60. 00 06000 LABORATORY	0	0)	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0)	0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0)	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	C)	0 0	0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0)	0 0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0)	0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		_				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	c		0 0	0	200. 00

Health Financial Systems Laffay	ette Regional R	ehabilitation	Hospi	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2020 To 12/31/2020		
Title XIX H					PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				-	1	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 304, 657		
57.00 05700 CT SCAN	0	0		0 0	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0. 000000	
60. 00 06000 LABORATORY	0	0		0 691, 774	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 483, 821	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 605, 460	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 171, 444	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 919, 329	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 528, 798	0. 000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 072, 316	0. 000000	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0 262, 450	0. 000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 99, 839	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS			•			
91.00 09100 EMERGENCY	0	0		0 0	0.00000	91.00
91. 01 04951 OUTPATI ENT THERAPY	0	0		0 0	0. 000000	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0	0		o o	0. 000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0		0 10, 139, 888	i	200.00
		•	•			•

Health Financial Systems Laffaye	ette Regional Re	ehabilitation	Hospi	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider C	CN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/27/2021 8:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient	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 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	· · ·					1
91.00 09100 EMERGENCY	0.000000	0		0 0	0	91.00
91. 01 04951 OUTPATI ENT THERAPY	0. 000000	0		0 0	0	91.01
93.00 04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS			•			1
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		0		0 0	0	200. 00

Laffayette Regional	Reha	abilitation Hospi	
		Dravidar CCN, 1E 2042	Darel ad.

In Lieu of Form CMS-2552-10

alth Financial Systems Laffayette Regional Re	ehabilitation Hospi	In Lie	eu of Form CMS-2	2552-1
OMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-3042	Peri od:	Worksheet D-1	
		From 01/01/2020 To 12/31/2020		
	Title XVIII	Hospi tal	PPS	ο μιι
Cost Center Description	L			
			1.00	
PART I – ALL PROVIDER COMPONENTS				
.00 Inpatient days (including private room days and swing-bed days	ays, excluding newborn)		7, 431	1.0
.00 Inpatient days (including private room days, excluding swing			7, 431	2.0
.00 Private room days (excluding swing-bed and observation bed	days). If you have only pr	ivate room days,	0	3. C
do not complete this line. .00 Semi-private room days (excluding swing-bed and observation	bod dave)		7, 431	4. C
.00 Total swing-bed SNF type inpatient days (including private i		er 31 of the cost		
reporting period			_	
.00 Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6. C
reporting period (if calendar year, enter 0 on this line) .00 Total swing-bed NF type inpatient days (including private re	com dave) through December	21 of the cost	0	7. C
reporting period	colli days) thi ough becember	ST OF THE COST	0	/. (
.00 Total swing-bed NF type inpatient days (including private re	oom days) after December 3	31 of the cost	0	8. C
reporting period (if calendar year, enter 0 on this line)				
.00 Total inpatient days including private room days applicable	e to the Program (excluding	swing-bed and	4, 658	9.0
newborn days) (see instructions) D.OO Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	room days)	0	10. C
through December 31 of the cost reporting period (see instru			_	
1.00 Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11. C
December 31 of the cost reporting period (if calendar year, 2.00 Swing-bed NF type inpatient days applicable to titles V or 2		o room dave)	0	12. C
through December 31 of the cost reporting period	xix only (meruaning privat	e room days)	0	12.0
3.00 Swing-bed NF type inpatient days applicable to titles V or 3	XIX only (including privat	e room days)	0	13.0
after December 31 of the cost reporting period (if calendar				
4.00 Medically necessary private room days applicable to the Prog 5.00 Total nursery days (title V or XIX only)	gram (excluding swing-bed	days)	0	
6.00 Nursery days (title V or XIX only)			0	
SWING BED ADJUSTMENT				
7.00 Medicare rate for swing-bed SNF services applicable to servi	ices through December 31 c	of the cost	0.00	17.0
reporting period 8.00 Medicare rate for swing-bed SNF services applicable to servi	icos ofter December 21 of	the cost	0.00	10 0
reporting period	rees arter becember 51 of	the cost	0.00	10.0
9.00 Medicaid rate for swing-bed NF services applicable to service reporting period	ces through December 31 of	the cost	0.00	19. C
0.00 Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 of t	he cost	0.00	20.0
reporting period				
1.00 Total general inpatient routine service cost (see instruction			8, 348, 763	
 Swing-bed cost applicable to SNF type services through Decent 5 x line 17) 	mber 31 of the cost report	ing period (line	0	22.0
3.00 Swing-bed cost applicable to SNF type services after December	er 31 of the cost reportir	ng period (line 6	0	23.0
x line 18)				
4.00 Swing-bed cost applicable to NF type services through Decem	ber 31 of the cost reporti	ng period (line	0	24.0
7 x line 19) 5.00 Swing-bed cost applicable to NF type services after Decembe	er 31 of the cost reporting	period (line 8	0	25.0
x line 20)	· · · · · · · · · · · · · · · · · · ·	,	_	
6.00 Total swing-bed cost (see instructions)			0	
7.00 General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	t (line 21 minus line 26)		8, 348, 763	27.0
8.00 General inpatient routine service charges (excluding swing-	bed and observation bed ch	narges)	0	28.0
9.00 Private room charges (excluding swing-bed charges)		0	0	29. (
0.00 Semi-private room charges (excluding swing-bed charges)			0	
1.00 General inpatient routine service cost/charge ratio (line 2)	7 ÷ line 28)		0. 000000 0. 00	
2.00 Average private room per diem charge (line 29 ÷ line 3) 3.00 Average semi-private room per diem charge (line 30 ÷ line 4))		0.00	
4.00 Average per diem private room charge differential (line 32)		tions)	0.00	
5.00 Average per diem private room cost differential (line 34 x)	line 31)		0.00	
6.00 Private room cost differential adjustment (line 3 x line 35	-	fforontial (1)	0	
7.00 General inpatient routine service cost net of swing-bed cos 27 minus line 36)	and private room cost di	rrerential (line	8, 348, 763	37.0
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL	DJUSTMENTS			
8.00 Adjusted general inpatient routine service cost per diem (se			1, 123. 50	
	no 28)		5, 233, 263	39.0
9.00 Program general inpatient routine service cost (line 9 x lin	-			10 0
 9.00 Program general inpatient routine service cost (line 9 x lin 0.00 Medically necessary private room cost applicable to the Program general inpatient routine service cost (line 	gram (line 14 x line 35)		0 5, 233, 263	

	Financial Systems Laffaye ATION OF INPATIENT OPERATING COST	ette Regional Reh	abilitation Provider CC	CN: 15-3042	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre 7/27/2021 8:1	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient CostIn	Total patient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	<u>4)</u> 5. 00	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
12.00	Intensive Care Type Inpatient Hospital Units						12.00
	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNI T						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00 47.00
47.00	Cost Center Description						47.00
	·····					1.00	
	Program inpatient ancillary service cost (Wks					2, 809, 619	
49.00	Total Program inpatient costs (sum of lines 4	11 through 48)(se	e instructio	ns)		8, 042, 882	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routine se	rvices (from	Wkst D sum	of Parts L and	1, 052, 335	50.00
50.00		attent foutthe se				1,032,333	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	271, 184	51.00
	and IV)						
	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		tod non nhy	cial an anacth	otict and	1, 323, 519 6, 719, 363	
53.00	medical education costs (line 49 minus line 5	5 1	itea, non-phy	sician anestri	etist, and	0, /19, 303	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	/					
	Program discharges					0	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)	ng cost and targ	ist smount (1		Lino E2)	0	56.00 57.00
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and targ	jet amount (i	The so minus	TTHE 53)	0	57.00
	Lesser of lines 53/54 or 55 from the cost rep	orting period en	nding 1996, u	pdated and co	mpounded by the	0.00	
	market basket	0.1	0		. ,		
	Lesser of lines 53/54 or 55 from prior year of				*h + h	0.00	
61.00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than				2	0	61.00
	amount (line 56), otherwise enter zero (see i		(11163 54 X	00), 01 1/0 01	the target		
62.00	Relief payment (see instructions)	,				0	
63.00	Allowable Inpatient cost plus incentive payme	ent (see instruct	i ons)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decemb	or 31 of the	cost reporti	na period (See	0	64.00
04.00	instructions) (title XVIII only)	IS THOUGH Decemb		cost reporti	ng period (see	0	04.00
65.00	Medicare swing-bed SNF inpatient routine cost	ts after December	31 of the c	ost reporting	period (See	0	65.00
(instructions) (title XVIII only)	+- (1: (4				0	
66.00	Total Medicare swing-bed SNF inpatient routir CAH (see instructions)	ie costs (line 64	pius line 6	5)(title XVII	i oniy). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through D	ecember 31 o	f the cost re	porting period	0	67.00
	(line 12 x line 19)	ç					
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after Dec	ember 31 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	coutine costs (li	ne 67 + line	68)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU						07.00
	Skilled nursing facility/other nursing facili	-					70.00
71.00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		line 14 v li	ne 35)			72.00 73.00
74.00	Total Program general inpatient routine servi						74.00
75.00	Capital-related cost allocated to inpatient r	•			art II, column		75.00
7/ 00	26, line 45)	2)					7/ 00
76.00 77.00	Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line						76.00 77.00
	Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess		vider record	s)			79.00
80.00	Total Program routine service costs for compa		st limitation	(line 78 min	us line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82.00 83.00
	Program inpatient ancillary services (see ins						84.00
	Utilization review - physician compensation (;)				85.00
86.00	Total Program inpatient operating costs (sum		ough 85)				86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87.00
	Adjusted general inpatient routine cost per c		ine 2)			0.00	
	Observation bed cost (line 87 x line 88) (see		-				89.00

Health Financial Systems	_affayette Regional	Rehabilitation	Hospi	In Lie	eu of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS TH	ROUGH COST	·				
90.00 Capital-related cost	1, 678, 78	2 8, 348, 763	0. 20108	2 0	0	90.00
91.00 Nursing School cost		0 8, 348, 763	0.00000	0 0	0	91.00
92.00 Allied health cost		0 8, 348, 763	0.00000	0 0	0	92.00
93.00 All other Medical Education		0 8, 348, 763	0. 00000	0 0	0	93.00

Laffayette	Regi onal	Reha	abilitation Hospi	

PART I - AL INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATI	Systems Laffayette Regional Reha NPATIENT OPERATING COST	Provi der CCN: 15-3042	Peri od:	u of Form CMS-2 Worksheet D-1					
PART I - AL INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT ENT INPATIENT			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/27/2021 8:13	pareo 8 pm				
PART I - AL INPATIENT ENT ENT 100 Inpatient of 00 1100 100 1100 1100 1100 1100 1100 1100 1101 1102 1101 <td< th=""><th></th><th>Title XIX</th><th>Hospi tal</th><th>PPS</th><th></th></td<>		Title XIX	Hospi tal	PPS					
INPATIENT ENTER 00 Inpatient of private rood do not composition of the second do not	Center Description			1.00					
00 Inpatient of Inpatient of OPrivate roo do not comp of Semi-privation Total swing reporting p OD Total nurse Swing-bed N after Decen A CO Medical y r SO Total nurse Medicare ra reporting p OD Total swing SWING BED A Nursery day SWING BED A O Medicare ra reporting p O Total swing Swing-bed o X line 18 Swing-bed o X line 10 Swing-bed o X line 10 Swing-bed o X line 10 Swing-bed o X line 20 O O Semi-private O O Semi-private O O Average per Average per Avera	ALL PROVIDER COMPONENTS								
00 Inpatient of OPrivate roo do not comp reporting p 00 Semi-privat 00 Total swing reporting p 00 Swing-bed S 00 Swing-bed S 00 Swing-bed N after Decer after Decer 1.00 Swing-bed N after Decer after Decer 2.00 Medical yr 5.00 Nursery day 5.00 Nursery day 5.00 Nursery day 5.00 Medicare ra reporting p 7.00 Medicaid ra reporting p 8.00 Swing-bed o x line 18 9.00 Swing-bed o x line 18 4.00 Swing-bed o x line 18 5.00 Swing-bed o x line 20 6.00 General inp 9.00 Frivate roo	days (including private room days and swing-bed days	s, excluding newborn)		7, 431	1.				
00 Semi-privation 00 Total swing 00 Total swing 00 Total swing 00 Total swing reporting p 00 Total swing 00 Total swing 00 Total inpan newborn day 00 Swing-bed S through Dec 1.00 Swing-bed M through Dec 3.00 Medical yr 6.00 Swing-bed M 6.00 Nursery day SWING BED A 7.00 Medical ra reporting p 7.00 Medicaid ra reporting p 8.00 Medicaid ra reporting p 9.00 Medicaid ra reporting p 1.00 Total gener 2.00 Swing-bed G 5 x line 18 <tr< td=""><td colspan="9">Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.</td></tr<>	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.								
00 Total swing reporting p 00 Total inpatinewborn day through Dec 00 Swing-bed S 00 Swing-bed S 00 Swing-bed N 1.00 Swing-bed N after Decer 1.00 Medically r 5.00 Medicare ra reporting p 6.00 Medicare ra reporting p 7.00 Medicaid ra reporting p 8.00 Medicaid ra reporting p 9.00 Medicaid ra reporting p 1.00 Swing-bed c 5.00 Swing-bed c 7 X line 10 8.00 Swing-bed c 7 X line 10 8.00 General inp 9.00 Frivate roo 9.00 General inp 9.00 Average per 9.00 Average per </td <td>ate room days (excluding swing-bed and observation be ng-bed SNF type inpatient days (including private roo</td> <td></td> <td>r 31 of the cost</td> <td>7, 431 0</td> <td>4. 5.</td>	ate room days (excluding swing-bed and observation be ng-bed SNF type inpatient days (including private roo		r 31 of the cost	7, 431 0	4. 5.				
00 Total swing reporting p 00 Total swing reporting p 00 Total swing reporting p 00 Total swing reporting p 00 Total inpatine newborn day b 00 Swing-bed S 1.00 Swing-bed S 00 Swing-bed N 1.00 Swing-bed N 1.00 Swing-bed N 1.00 Swing-bed N 1.00 Medically n 2.00 Swing-bed N 3.00 Medical re reporting p Medicaid ra reporting p Medicaid ra reporting p Medicaid ra reporting p Medicaid ra reporting p Swing-bed C 5 X line 18 1.00 Swing-bed C 5 X line 10 5 X line 20 5 X line 10 6 General inp 7 No 8.00 General inp 9.00 Fivate roo 9.00 Average per 9.00 Average per <	period ng-bed SNF type inpatient days (including private roc period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.				
reporting p newborn day through Dec book wing-bed S December 37 2.00 Swing-bed S December 37 2.00 Swing-bed N after Decen 3.00 Swing-bed N after Decen 4.00 Medical ly n 5.00 Total nurse 5.00 Nursery day SWING BED A Medicare ra reporting p 3.00 Medicare ra reporting p 3.00 Medicare ra reporting p 3.00 Medicare ra reporting p 3.00 Medicare ra reporting p 4.00 Swing-bed C 5 x line 10 5 x line 10 5 x line 10 5 x line 20 5 x li	ng-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7.				
newborn day 0.00 Swing-bed S through Dec 0.00 Swing-bed S December 37 2.00 Swing-bed M through Dec 3.00 Swing-bed M after December 37 5.00 Swing-bed M after December 37 5.00 Swing-bed M after December 37 5.00 Medically m 6.00 Medically m 7.00 Medicare ra reporting p 8.00 Medicaid ra reporting p 0.00 Swing-bed c 5 x line 18 0.00 Swing-bed c 5 x line 18 0.00 Swing-bed c 7 x line 19 0.00 Swing-bed c 7 x line 20 0.00 General inp 00 General inp 00	ng-bed NF type inpatient days (including private room period (if calendar year, enter 0 on this line)	-		0	8.				
through Dec becember 3 December 3 December 3 December 3 December 3 Second Swing-bed M after December 3 Cond Swing-bed M after December 3 Swing-bed M after December 3 December 3 Swing-bed M Swing-BED A Swing BED A Swing BED A Medicare rates reporting p Medicare rates reporting p Oo Medicaid rates reporting p Medicaid rates reporting p Do Medicaid rates reporting p Do Total gener Swing-bed o X line 18 Swing-bed o X line 19 Do O Swing-bed o X line 20 Do Total swing PRIVATE ROO Semi-private DO Average per Do Private roo Do Average per Do Average per Do Average per Do Private roo Do Semi-private roo Do Average per Do Private roo Do P	atient days including private room days applicable to ays) (see instructions)	0 . 0	U U	191					
December 37 2.00 Swing-bed N through Dec 3.00 Swing-bed N after Decen 3.00 Nursery day SWING BED A SWING BED A SWI	SNF type inpatient days applicable to title XVIII or ecember 31 of the cost reporting period (see instruct SNF type inpatient days applicable to title XVIII or	tions)	5,	0					
through Dec 00 Swing-bed N after Decem 00 Medically r 00 Total nurse 00 Nursery day SWING BED A 00 Medicare ra reporting p 00 Medicaid ra reporting p 00 Swing-bed c 5 x line 13 00 Swing-bed c 7 x line 20 00 Swing-bed c 7 x line 19 00 Swing-bed c 7 x line 19 00 Swing-bed c 7 x line 10 00 Swing-bed c 7 x line 10 00 Swing-bed c 00 Frivate roc 00 General ing 00 Private roc 00 Average per 00 Average per 00 Average per 00 Private roc 00 General ing 27 minus li	31 of the cost reporting period (if calendar year, er NF type inpatient days applicable to titles V or XI)	nter 0 on this line)	5,		12.				
 Medically r Total nursery day WING BED A Medicare ra reporting p Medicaid ra reporting p Swing-bed c x line 18 Swing-bed c x line 20 Swing-bed c x line 20 Swing-bed c x line 18 Swing-bed c x line 18 Swing-bed c x line 20 Total swing General ing PRIVATE ROC Serier and serier Average per 	ecember 31 of the cost reporting period NF type inpatient days applicable to titles V or XIX	(only (including privat	e room days)	0					
Nursery day SWING BED A SWING BED A OO Medicare ra reporting p reporting p OO Medicaid ra reporting p OO Total gener OO Swing-bed c x line 18) OO Swing-bed c x line 20) OO General inp PRIVATE ROC OO General inp OO Average per OO Average per OO Average per OO Private roc OO Private roc OO Average per OO Average per OO Private roc OO Private roc OO Private roc OO Private roc	ember 31 of the cost reporting period (if calendar ye necessary private room days applicable to the Progra			0					
SWING BED A .00 Medicare ray reporting p .00 Medicare ray reporting p .00 Medicaid ray reporting p .00 Total gener .00 Swing-bed of 5 x line 13 .00 Swing-bed of 7 x line 18 .00 Swing-bed of x line 20 .00 Swing-bed of x line 20 .00 Swing-bed of x line 20 .00 General inp .00 General inp .00 General inp .00 General inp .00 Average pri .00 Average pri .00 Average pri .00 Average pri .00 Private roo .00 Average pri .00 Average pri	sery days (title V or XIX only) ays (title V or XIX only)			0					
reporting p reporting p report vate roc roc Average per roc Average per roc Private roc roc General ing roc Average per roc Average per roc Private roc roc General ing roc Average per roc Average per roc Private roc	ADJUSTMENT								
reporting p Medicaid ra reporting p 00 Medicaid ra reporting p 00 Total gener 00 Swing-bed o 5 x line 13 00 Swing-bed o x line 18) 00 Swing-bed o x line 18) 00 Swing-bed o x line 20) 00 Total swing 00 General inp 00 Private roo 00 Semi -privat 00 Average per 00 Average per 00 Average per 00 Average per 00 Average per 00 Average per 00 Private roo 00 General inp 00 Average per 00 Average per 00 Average per 00 Private roo 00 General inp 00 Average per 00 Average per 00 Average per 00 Average per 00 Average per 00 Private roo		-		0.00					
reporting p reporting p reporting p roporting p outer swing-bed swing-bed x line 13 outer swing-bed x line 18 outer y x line 18 outer swing-bed x line 18 outer y x line 10 r x line 10 r x line 20 outer swing-bed x line 20 outer swing-bed y x line 20 outer swing-bed y x line 20 outer swing-bed roport rotal swing PRIVATE ROC outer private roc outer set outer outer set outer rotal swing PRIVATE ROC outer set rotal swing rotal swing outer rotal swing rotal swing rotal swing outer rotal swing rotal	rate for swing-bed SNF services applicable to service period rate for swing-bed NF services applicable to services			0.00					
reporting p .00 Total gener .00 Swing-bed o 5 x line 15 .00 Swing-bed o 7 x line 18 .00 Swing-bed o 7 x line 20 .00 Swing-bed o x line 20 .00 Total swing .00 General ing <u>PRIVATE ROO</u> .00 General ing .00 Average per .00 General ing .00 Average per .00 Average per .00 Average per .00 General ing .00 Average per .00 Average per .00 Average per .00 Average per .00 General ing .00 Average per .00 Average per .00 Average per .00 General ing .00 Average per .00 Average p		C		0.00					
5 x line 17 .00 Swing-bed of x line 18) .00 Swing-bed of 7 x line 19 .00 Swing-bed of x line 20) .00 Total swing .00 General ing <u>PRIVATE ROO</u> .00 General ing .00 General ing .00 Semi-private .00 Average per .00 General ing .00 Average per .00 Average per .00 Average per .00 General ing .00 Average per .00 Average per .00 Average per .00 General ing .00 Average per .00 Average per .00 General ing .00 Average per .00 Average per .00 General ing				8, 348, 763	21				
x line 18) .00 Swing-bed of 7 x line 19 Swing-bed of x line 20) .00 Total swing .00 General ing <u>PRIVATE ROO</u> .00 General ing .00 Private roo .00 Average per .00 Average pe			0 1 1	0					
7 x line 19 Swing-bed o x line 20) O Total swing O General ing PRIVATE ROO O General ing O Private roo O Semi-privat O Average pri O Average per O Average per			5 T X	0					
x line 20) x line 20) Total swing PRIVATE ROC CO General inp PRIVATE ROC 0 O Private roc 0 O Semi-privat 0 General inp 0 Average per 0 Average per 0 Average per 0 Average per 0 Average per 0 Private roc 0 General inp 2 minus li	cost applicable to NF type services through December 19) cost applicable to NF type services after December 3		0 1 1	0					
Constraint General inp PRIVATE ROO General inp PRIVATE ROO O OO General inp OO Semi-privat OO General inp OO General inp OO General inp OO Average pri OO Average per OO Average per OO Average per OO General inp OO Average per OO General inp OO Average per OO General inp OO General inp		si si the cost reporting	porrou (rine o	0					
.00General inp.00Private roc.00Semi-privat.00General inp.00Average pri.00Average sem.00Average per.00Average per.00Average per.00Average per.00General inp.00General inp.00General inp.00General inp.00General inp.01Average per	npatient routine service cost net of swing-bed cost (DOM DIFFERENTIAL ADJUSTMENT			8, 348, 763					
.00 Semi-privation .00 General inp .00 Average pri .00 Average sem .00 Average per .00 General inp .00 General inp .01 General inp .02 Tminus li	npatient routine service charges (excluding swing-bec	d and observation bed ch	arges)	0					
.00General ing.00Average pri.00Average sen.00Average per.00Average per.00Private roo.00General ing.27 minus li	oom charges (excluding swing-bed charges) ate room charges (excluding swing-bed charges)			0					
.00 Average pri .00 Average sen .00 Average per .00 Average per .00 Private roo .00 General in .00 General in .27 minus li 1	npatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000					
. 00 Average sen . 00 Average per . 00 Average per . 00 Private roo . 00 General inp . 27 minus li	rivate room per diem charge (line 29 ÷ line 3)			0.00					
00 Average per 00 Average per 00 Private roc 00 General ing 27 minus li	emi-private room per diem charge (line 30 ÷ line 4)			0.00					
00 Average per 00 Private roc 00 General inp 27 minus li	er diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00					
.00 General inp 27 minus li	er diem private room cost differential (line 34 x lir			0.00					
27 minus li	oom cost differential adjustment (line 3 x line 35)			0					
		and private room cost di	tterential (line	8, 348, 763	37				
	HOSPITAL AND SUBPROVIDERS ONLY NPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS							
	general inpatient routine service cost per diem (see			1, 123. 50	38				
0 0	eneral inpatient routine service cost (line 9 x line	-		214, 589					
	necessary private room cost applicable to the Progra gram general inpatient routine service cost (line 39			0 214, 589					

	yette Regional Rel			In Lie	u of Form CMS-:	
COMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-3042	Period: From 01/01/2020 To 12/31/2020		pared:
		Titl	e XIX	Hospi tal	7/27/2021 8:1 PPS	8 pm
Cost Center Description	Total Inpatient Costli	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit						42.00
43. 00 INTENSIVE CARE UNIT						43.00
44. 00 CORONARY CARE UNI T						44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT						45.00 46.00
47. 00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description				т.		
48.00 Program inpatient ancillary service cost (W	/kst D-3 col 3	Line 200)			1.00	48.00
49.00 Total Program inpatient costs (sum of lines			ons)		214, 589	
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program in [111]	patient routine s	ervices (from	n Wkst. D, sun	n of Parts I and	43, 151	50.00
51.00 Pass through costs applicable to Program ir	patient ancillary	services (fr	rom Wkst. D, s	sum of Parts II	0	51.00
and IV)	50 1 54)				40.454	50.00
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost excl		ated non-phy	usician anesth	netist and	43, 151 171, 438	
medical education costs (line 49 minus line		atea, non prij		letrot, and	171,100	00.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges 55.00 Target amount per discharge					0.00	
56.00 Target amount (line 54 x line 55)					0	
57.00 Difference between adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	line 53)	0	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost r	reporting period e	nding 1996 i	undated and co	mounded by the	0.00	
market basket	cporting period c	naring 1770, c		inpounded by the	0.00	07.00
60.00 Lesser of lines 53/54 or 55 from prior year				46 6	0.00	
61.00 If line 53/54 is less than the lower of lin which operating costs (line 53) are less th					0	61.00
amount (line 56), otherwise enter zero (see				the target		
62.00 Relief payment (see instructions)	mont (ooo instrus	+: -===)			0	
63.00 Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64.00 Medicare swing-bed SNF inpatient routine co	sts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64.00
65.00 Medicare swing-bed SNF inpatient routine co	sts after Decembe	r 31 of the c	cost reporting	n period (See	0	65.00
instructions)(title XVIII only)			1		0	05.00
66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 plus line 6	55)(title XVII	l only). For	0	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	of the cost re	eporting period	0	67.00
(line 12 x line 19)						
68.00 Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost repo	orting period	0	68.00
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	e 68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHER					ſ	
70.00 Skilled nursing facility/other nursing faci 71.00 Adjusted general inpatient routine service				1		70.00
72.00 Program routine service cost (line 9 x line			2)			72.00
73.00 Medically necessary private room cost appli	-					73.00
74.00 Total Program general inpatient routine ser 75.00 Capital-related cost allocated to inpatient	•			Part II column		74.00 75.00
26, line 45)	Toutine service		ior Kaneet D, T			/ 3.00
76.00 Per diem capital-related costs (line 75 ÷ 1						76.00
77.00 Program capital-related costs (line 9 x lin 78.00 Inpatient routine service cost (line 74 min						77.00 78.00
79.00 Aggregate charges to beneficiaries for exce		ovider record	ls)			79.00
80.00 Total Program routine service costs for com	•	st limitatior	n (line 78 mir	nus line 79)		80.00
81.00 Inpatient routine service cost per diem lim 82.00 Inpatient routine service cost limitation (81.00 82.00
83.00 Reasonable inpatient routine service cost	· . · .)				83.00
84.00 Program inpatient ancillary services (see i		- >				84.00
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (su						85.00 86.00
PART IV - COMPUTATION OF OBSERVATION BED PA						00.00
87.00 Total observation bed days (see instruction	is)				0	
88.00 Adjusted general inpatient routine cost per 89.00 Observation bed cost (line 87 x line 88) (s		iine 2)				88.00 89.00
or of the cost (The or A The oo) (S					ı 0	07.00

Health Financial Systems L	affayette Regional	Rehabilitation	Hospi	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THE	OUGH COST					
90.00 Capital-related cost	1, 678, 78	2 8, 348, 763	0. 20108	2 0	0	90.00
91.00 Nursing School cost		0 8, 348, 763	0.00000	0 0	0	91.00
92.00 Allied health cost	1	0 8, 348, 763	0.00000	0 0	0	92.00
93.00 All other Medical Education		0 8, 348, 763	0.00000	0 0	0	93.00

Health Financi	al Systems Laffayette Regional Re	ehabilitation	Hospi	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCI	ILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
				From 01/01/2020 To 12/31/2020		nared
				10 12/01/2020	7/27/2021 8:1	
		Title	XVIII	Hospi tal	PPS	
Cc	ost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
	NT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	DULTS & PEDIATRICS			4, 192, 200	[30, 00
	RY SERVICE COST CENTERS		1	4, 172, 200		30.00
	ADI OLOGY-DI AGNOSTI C		0. 14204	205, 330	29, 165	54.00
57.00 05700 C1	T SCAN		0.00000	0 0	0	57.00
58.00 05800 MA	AGNETIC RESONANCE IMAGING (MRI)		0.00000	0 0	0	58.00
60.00 06000 LA	ABORATORY		0. 19274	520, 659	100, 357	60.00
	ESPI RATORY THERAPY		0. 53613	308, 828		65.00
	HYSI CAL THERAPY		0. 55723			
	CCUPATI ONAL THERAPY		0. 54274			
	PEECH PATHOLOGY		0. 44531	-		
	EDICAL SUPPLIES CHARGED TO PATIENTS		0.66330			
	RUGS CHARGED TO PATIENTS		0. 41371			
	ENAL DI ALYSI S		0. 74847			1
	THER ANCI LLARY SERVICE COST CENTERS		1.96752	28 66, 849	131, 527	76.00
91.00 09100 EN	ENT SERVICE COST CENTERS		0.00000		0	91.00
	UTPATIENT THERAPY		0.00000		0	
	UTPATIENT THERAPT UTPATIENT WOUND CENTER		0.00000		-	91.01
	EIMBURSABLE COST CENTERS		0.0000		0	93.00
	MBULANCE SERVICES					95.00
	otal (sum of lines 50 through 94 and 96 through 98)			5, 744, 545	2, 809, 619	
	ess PBP Clinic Laboratory Services-Program only charg	es (line 61)		0, , , , , , , , , , , , , , , , , , ,	2,007,017	200.00
	et charges (line 200 minus line 201)			5, 744, 545		202.00
			i.	2, , 0 10	1	

	Financial Systems	Laffayette Regional Reha				eu of Form CMS-	
I NPATI E	ENT ANCILLARY SERVICE COST APPORTI	ONMENT	Provider C	CN: 15-3042	Period: From 01/01/2020	Worksheet D-3	
					To 12/31/2020		pared:
						7/27/2021 8:1	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos		Inpati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CE	NTERS				1	
-	03000 ADULTS & PEDIATRICS				C		30.00
	ANCI LLARY SERVICE COST CENTERS			0.1400	10		1 54 00
	05400 RADI OLOGY-DI AGNOSTI C			0.1420			
	05700 CT SCAN			0.0000		0	
	05800 MAGNETIC RESONANCE I MAGI NG	(MRI)		0.0000		0	
				0. 1927		0	60.00
				0. 5361		0	
	06600 PHYSI CAL THERAPY			0.5572		0	
	06700 OCCUPATI ONAL THERAPY			0. 5427		0	
	06800 SPEECH PATHOLOGY			0. 4453		0	
	07100 MEDICAL SUPPLIES CHARGED TO 07300 DRUGS CHARGED TO PATIENTS	PATTENTS		0. 66330		0	71.00
	07300 DRUGS CHARGED TO PATTENTS			0. 4137			73.00
	03950 OTHER ANCI LLARY SERVICE COS	T CENTEDS		1. 9675	-	-	
	OUTPATIENT SERVICE COST CENTERS	I CENTERS		1. 9075.	20 (<u>/</u> 0	70.00
	09100 EMERGENCY			0.0000	20 00	0	91.00
	04951 OUTPATIENT THERAPY			0.0000			•
	04950 OUTPATIENT WOUND CENTER			0.0000			•
	OTHER REIMBURSABLE COST CENTERS			0.0000		<u> </u>	75.00
	09500 AMBULANCE SERVICES						95.00
200.00	Total (sum of lines 50 through	up 94 and 96 through 98)			0	0	200.00
200.00		Services-Program only charges	(line 61)			0	200.00
201.00	Net charges (line 200 minus						201.00
202.00	Ince charges (The 200 III hus	1110 201)		I		'I	1202.0

CULA	ATION OF REIMBURSEMENT SETTLEMENT	oilitation Hospi Provider CCN: 15-3042	Peri od: From 01/01/2020 To 12/31/2020		pare
		Title XVIII	Hospi tal	7/27/2021 8:1 PPS	8 pm
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	-
) (Medical and other services (see instructions)			0	
	Medical and other services reimbursed under OPPS (see instructions)	ons)		0	
	OPPS payments Outlier payment (see instructions)			0	
	Outlier reconciliation amount (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instruc-	tions)		0.000	5
	Line 2 times line 5			0	
	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00 0	
	Ancillary service other pass through costs from Wkst. D, Pt. 1	/, col. 13, line 200		0	
	Organ acquisitions			0	
	Total cost (sum of lines 1 and 10) (see instructions)			0	11
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				1
	Ancillary service charges			0	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ne 69)		0	
	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14
	Aggregate amount actually collected from patients liable for pa	avment for services on	a charge basis	0	15
	Amounts that would have been realized from patients liable for	5	0	0	
	had such payment been made in accordance with 42 CFR §413.13(e))			
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	
	Excess of customary charges over reasonable cost (complete only	vifline 18 exceeds li	ne 11) (see	0	
	instructions)		, ,		
	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20
	instructions) Lesser of cost or charges (see instructions)			0	21
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24
	Deductibles and coinsurance amounts (for CAH, see instructions))		0	25
	Deductibles and Coinsurance amounts relating to amount on line		ructions)	0	26
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	2 and 23] (see	0	27
	instructions) Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)	10 50)		0	
	Subtotal (sum of lines 27 through 29)			0	
	Primary payer payments			0	
00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		0	32
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	(ctions)		0	
	Subtotal (see instructions)			0	
00	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions))		0	39
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	ed devices (see instruc	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			0	
	Sequestration adjustment (see instructions)			0	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40
00	Interim payments			0	41
	Interim payments-PARHM			-	41
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42
	Balance due provider/program (see instructions)			0	
01	Balance due provider/program-PARHM (see instructions)				43
ļ	Protested amounts (nonallowable cost report items) in accordance §115.2	ce with CMS Pub. 15-2,	chapter 1,	0	44
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90
	Outlier reconciliation adjustment amount (see instructions)			0	
00	The rate used to calculate the Time Value of Money			0.00	92
	Time Value of Money (see instructions)				93
11 1	Total (sum of lines 91 and 93)			0	9

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-3042	Period: From 01/01, To 12/31,		Worksheet E- Part I Date/Time Pr 7/27/2021 8:	repa	
		Title	XVIII	Hospi ta	1	PPS	10	рш
		Inpatien			Par			
		mm/dd/yyyy	Amount		vvv	Amount	+	
		1.00	2.00	3.00		4.00	+	
1.00	Total interim payments paid to provider		7, 482, 1				0	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,							
2 00	write "NONE" or enter a zero							2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate							3.00
	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	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
	Provider to Program							
3.50 3.51	ADJUSTMENTS TO PROGRAM			0			0	3.50
3.51				0			0	3.51 3.52
3.52				0			0	3.52
3.54				0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0			õ	3.99
	3. 50-3. 98)							
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		7, 482, 1	80			0	4. OC
	(transfer to Wkst. E or Wkst. E-3, line and column as							
	appropri ate)						_	
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after							5. OC
5.00	desk review. Also show date of each payment. If none,							5.00
	write "NONE" or enter a zero. (1)							
	Program to Provider			1				
5.01	TENTATI VE TO PROVI DER			0			0	5.01
5.02				0			0	5.02
5.03				0			0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0			0	5.50
5.50	IENTATIVE TO PROGRAM			0			0	5.50
5.52				0			0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0			õ	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		9	96			0	6.01
6.02	SETTLEMENT TO PROGRAM		7 400 1	0			0	6.02
7.00	Total Medicare program liability (see instructions)		7, 483, 1		tor		0	7.00
				Contrac Number		NPR Date (Mo/Day/Yr)		
		C)	1.00		2.00	+	
	Name of Contractor							8.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prep 7/27/2021 8:18	pared
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			7, 304, 994	
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0155	
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			235, 221	3.
. 00	Outlier Payments			101, 327	4.
. 00	Unweighted intern and resident FTE count in the most receipto November 15, 2004 (see instructions)	nt cost reporting period ei	nding on or prior	0.00	5.
. 01	Cap increases for the unweighted intern and resident FTE (count for residents that we	re displaced by	0.00	5.
	program or hospital closure, that would not be counted wi				
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	
. 00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	period of a "new	0.00	7.
. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents with	hip the new program growth .	and of a "now	0.00	8.
. 00	teaching program" (see instructions)	In the new program growth p		0.00	0.
. 00	Intern and resident count for IRF PPS medical education ad	djustment (see instructions))	0.00	9
0.00	Average Daily Census (see instructions)			20. 303279	10
1.00	Teaching Adjustment Factor (see instructions)			0.00000	11
2.00	Teaching Adjustment (see instructions)			0	12
3.00	Total PPS Payment (see instructions)			7, 641, 542	13
4.00	Nursing and Allied Health Managed Care payments (see inst	ruction)		0	14
5.00	Organ acquisition (DO NOT USE THIS LINE)				15
6.00		instructions)		0	
7.00	Subtotal (see instructions)			7, 641, 542	
8.00				10,000	
	Subtotal (line 17 less line 18).			7, 631, 542	
0.00				67,364	
1.00 2.00				7, 564, 178	
2.00 3.00				41, 888 7, 522, 290	
4.00		arvicas) (see instructions)		16, 313	
	Adjusted reimbursable bad debts (see instructions)			10, 603	
	Allowable bad debts for dual eligible beneficiaries (see i	instructions)		9, 108	
	Subtotal (sum of lines 23 and 25)			7, 532, 893	
3.00		4. line 49)		0	28
9.00				0	29
0. 00	Outlier payments reconciliation			0	30
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
1.50		ti ons)		0	31
1. 99	Demonstration payment adjustment amount before sequestration	i on		0	31
	Total amount payable to the provider (see instructions)			7, 532, 893	
2. 01				49, 717	
2.02		on		0	
	Interim payments			7, 482, 180	
4.00	Tentative settlement (for contractor use only)			0	
5.00	Balance due provider/program (line 32 minus lines 32.01, 3		abantan 1	996	
6.00	Protested amounts (nonallowable cost report items) in accessible.	proance with CMS Pub. 15-2,	cnapter 1,	0	36
	TO BE COMPLETED BY CONTRACTOR				
D. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			101, 327	50
1.00	5	s)			51
					52

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2020	Worksheet G	
ly)	ype accounting records, comprete the General Fund corumn			To 12/31/2020	Date/Time Pre 7/27/2021 8:1	
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	19, 563		0 0	0	1
00	Temporary investments	0		0 0	0	2
00	Notes receivable	0		0 0	0	
00	Accounts receivable	3, 542, 309		0 0	0	
00	Other receivable	1 452 011		0 0	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	-1, 452, 811 74, 462		0 0	0	
00	Prepaid expenses	233, 810		0 0	0	
00	Other current assets	16, 752		0 0	0	
. 00	Due from other funds	0		0 0	0	10
00	Total current assets (sum of lines 1-10)	2, 434, 085		0 0	0	11
	FI XED_ASSETS		1	-1 -	-	1
00	Land	0		0 0		
. 00	Land improvements Accumulated depreciation	0		0 0	0	
	Buildings	78, 186		0 0	0	
00	Accumulated depreciation	-8, 970		0 0	0	
	Leasehold improvements	0		0 0	0	
	Accumulated depreciation	0		0 0	0	18
	Fixed equipment	22, 178		0 0	0	19
	Accumulated depreciation	-19, 650		0 0	0	
	Automobiles and trucks	61, 836		0 0	0	
	Accumulated depreciation Major movable equipment	-12, 388 2, 664, 491		0 0	0	
	Accumulated depreciation	-1, 855, 674		0 0	0	
	Mi nor equipment depreciable	-1, 035, 074		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	27
. 00	Accumulated depreciation	0		0 0	0	28
	Minor equipment-nondepreciable	0		0 0		
. 00	Total fixed assets (sum of lines 12-29)	930, 009		0 0	0	0 30
. 00	OTHER ASSETS Investments	0		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	
. 00	Due from owners/officers	0		0 0	0	
	Other assets	135, 809, 991		0 0	0	
. 00	Total other assets (sum of lines 31-34)	135, 809, 991		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	139, 174, 085		0 0	0	36
	CURRENT LI ABI LI TI ES		1	1	L	
	Accounts payable	296, 126		0 0	0	
. 00 . 00	Salaries, wages, and fees payable Payroll taxes payable	456, 726 344, 991		0 0 0 0	0	
00	Notes and Loans payable (short term)	344, 991			0	
	Deferred income	0		0 0	0	
. 00	Accel erated payments	0				42
. 00	Due to other funds	0		0 0	0	43
. 00	Other current liabilities	153, 091, 241		0 0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	154, 189, 084		0 0	0	45
	LONG TERM LIABILITIES		1	a		
. 00	Mortgage payable	279 440		0 0	0	
. 00 . 00	Notes payable Unsecured Loans	278, 460		0 0	0	
	Other long term liabilities	920, 536		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	1, 198, 996		0 0		
00	Total liabilities (sum of lines 45 and 50)	155, 388, 080		0 0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	-16, 213, 995				52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56
00	Plant fund balance - reserve for plant improvement,				0	
					, 0	1 50
. 00 . 00 . 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-16, 213, 995		0 0	0	59

Heal th	Financial Systems Laffaye	ette Regional Re	habilitation I	Hospi	In Li	eu of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	0.00	0.00	1.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00 -15,361,679	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-852, 316				2.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	-16, 213, 995		0	0	3.00 4.00
5.00	Additions (crediti adjustments) (specify)	0			0	0	5.00
6.00		0			0	0	6.00
7.00 8.00		0			0	0	7.00 8.00
9.00		0			0	0	9.00
10.00	Total additions (sum of line 4-9)		0				10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	-16, 213, 995		0		11. 00 12. 00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00 16.00		0			0	0	15.00 16.00
17.00		0			0	0	17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		0 -16, 213, 995		(18. 00 19. 00
19.00	sheet (line 11 minus line 18)		-10, 213, 773			,	17.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1.00 2.00
2.00 3.00	Total (sum of line 1 and line 2)	0			0		2.00 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 10.00	Total additions (sum of line 4-9)	0	0		0		9.00 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 14.00			0				13.00 14.00
15.00			0				15.00
16.00 17.00			0				16. 00 17. 00
17.00	Total deductions (sum of lines 12–17)	О	0		0		17.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

IAIEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-3042	Period: From 01/01/202 To 12/31/202		eparec
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
~ ~	General Inpatient Routine Services	r			/ (00 T00	
. 00	Hospital		6, 689, 7	00	6, 689, 700	
. 00	SUBPROVIDER - IPF					2.
. 00	SUBPROVIDER - IRF					3.
. 00	SUBPROVI DER					4.
. 00	Swing bed - SNF			0	0	
. 00	Swing bed - NF			0	0	
. 00	SKILLED NURSING FACILITY			0	0	
. 00	NURSING FACILITY					8.
. 00	OTHER LONG TERM CARE		((00 7	00	((00 700	9.
0.00	Total general inpatient care services (sum of lines 1-9)		6, 689, 7	00	6, 689, 700	10.
1 00	Intensive Care Type Inpatient Hospital Services					1 1 1
1.00 2.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T					11.
						12.
3.00 4.00	BURN INTENSIVE CARE UNIT					13.
	SURGICAL INTENSIVE CARE UNIT					
5.00 6.00	OTHER SPECIAL CARE (SPECIFY)	1.000		0	0	15.
6.00	Total intensive care type inpatient hospital services (sum of I 11-15)	ines		0	0	10.
7.00	Total inpatient routine care services (sum of lines 10 and 16)		6, 689, 7	00	6, 689, 700	17.
8.00	Ancillary services		9, 078, 4			
9.00	Outpatient services		9,078,4	0 1,001,4	0 0	
0.00	RURAL HEALTH CLINIC			0	0 0	
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0 0	
2.00	HOME HEALTH AGENCY			0	0 0	
3.00	AMBULANCE SERVICES			0	0 0	
4.00	CMHC			0	0	24.
5.00	AMBULATORY SURGICAL CENTER (D. P.)					25.
6.00	HOSPICE					26.
7.00	OTHER (SPECIFY)			0	0 0	
8.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst	15, 768, 1	26 1, 061, 4	-	
	G-3, line 1)					
	PART II - OPERATING EXPENSES	I				
9.00	Operating expenses (per Wkst. A, column 3, line 200)			13, 244, 2	15	29.
0.00	ADD (SPECIFY)			0		30.
1.00				0		31.
2.00				0		32.
3.00				0		33.
4.00				0		34.
5.00				0		35.
6.00	Total additions (sum of lines 30-35)				0	36.
7.00	DEDUCT (SPECI FY)			0		37.
8.00				0		38.
9.00				0		39.
0.00				0		40.
1.00				0		41.
2.00	Total deductions (sum of lines 37-41)				0	42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		13, 244, 2	15	43.
	to Wkst. G-3, line 4)			1		1

STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-3042 Period:			Worksheet G-3		
			From 01/01/2020		
To 12/31/2020			Date/Time Prepared: 7/27/2021 8:18 pm		
				1/2//2021 8:18	s pm
			-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		16, 829, 588	1.00
2.00	Less contractual allowances and discounts on patients' accounts			5, 271, 742	2.00
3.00	Net patient revenues (line 1 minus line 2)			11, 557, 846	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			13, 244, 215	
5.00	Net income from service to patients (line 3 minus line 4)			-1, 686, 369	
	OTHER INCOME		1	, ,	
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			143	7.00
8.00	Revenues from telephone and other miscellaneous communication services			0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			9, 005	
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other the	han patients		0	16.00
17.00				0	17.00
18.00				51	18.00
19.00				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MISC INC, TRANSPORT, EMP PHYS SVCS			222, 530	
24.50	COVI D-19 PHE Fundi ng			602, 324	
25.00	Total other income (sum of lines 6-24)			834, 053	
	Total (line 5 plus line 25)			-852, 316	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-852, 316	29.00