neai tii riilalici a	ai systems	Larayerre kegrunar kenad	nii tati on nospi t		THE LIEU OF FORM CW3-2002-1
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fail	lure to report can r	esult in all in	nterim FORM APPROVED
payments made	since the beginning of the cost	reporting period being	deemed overpayments	(42 USC 1395g)	OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 15-30	From 01/0	Worksheet S Parts I-III Date/Time Prepared: 5/16/2022 12:32 pm
PART I - COST	REPORT STATUS				
Provi der use only	1. [ X ] Electronically prepared 2. [ ] Manually prepared cost	•		Date: 5	5/16/2022 Time: 12:32 pm
ass s y	3. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.	report enter the number		er resubmitted	this cost report
Contractor use only	(2) Settled without Audit 8	. Contractor No.	or this Provider CCN		

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Lafayette Regional Rehabilitation Hospital (15-3042) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Trish	na Niemuth	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Trisha Niemuth			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY	_					
1.00 Hospi tal	0	128, 826	0	0	0	1.00
2.00 Subprovi der - 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	o	0		0	9. 00
200. 00 Total	0	128, 826	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.

Health Financial Systems Lafavette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3042 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/16/2022 12:32 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 950 Park East Bl vd PO Box: 1.00 State: IN County: TI PPECANOE 2.00 City: Lafayette Zip Code: 47905 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 153042 29200 5 04/18/2013 Ν 3.00 Lafavette Regional Rehabilitation Hospital Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 N Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν Ν rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 2 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems Lafayette Regi	onal Rehab	ilitation Ho	ospi t		In Lieu	of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	CN: 15-3042	Period: From 01/0 To 12/3	01/2021 81/2021	Part I Date/Ti	eet S-2 me Pre 022 12:	pared:
	In-State Medicaid paid days	Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	d 0 rs Med	ther di cai d days	
	1.00	2. 00	3. 00	4. 00	5. 00		5. 00	21.00
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 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.	7:	8 0		0	ç	0		24. 00
				Urban/F	Rural S [	Date of 2.0		
26.00 Enter your standard geographic classification (not w	age) statu:	s at the bed	ainnina of t		1	2. (	50	26. 00
cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban column the effective date of the geographic reclassification (SCH), enter the effective date of the geographic reclassification (SCH), enter the effective date of the geographic reclassification (SCH), enter the effective date of the geographic reclassification (SCH), enter the effective date of the geographic reclassification (SCH), enter the effective date of the geographic reclassification (SCH), enter the effective date of the geographic reclassification (SCH), enter the effective date of the geographic reclassification (SCH), enter the effective date of the geographic classification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the geographic reclassification (not we report the effective date of the effective date	rrural. vage) status or "2" for i ication in	s at the end rural. If ap column 2.	of the cos	t	1			27. 00
effect in the cost reporting period.								
				Begi n		Endi		
36.00 Enter applicable beginning and ending dates of SCH s	tatus. Sub	script line	36 for numb		00	2. (	50	36. 00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), enter	es.				0			37. 00
is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)								37. 01
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number center subsequent dates.							<b>A</b> .	38. 00
				1.		Y/ 2. (		
39.00 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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (ii), on the mileage	r (iii)? Ent e requiremen	er in colum nts in	me N n		N		39. 00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for y				N		40. 00
					V 1.00	2. 00	XIX	
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00 Does this facility qualify and receive Capital payme	nt for disp	proporti onat	e share in	accordance	N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc					N	N	N	46. 00

with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N N A 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		The fire cordinar 2, for discharges on or after october 1. (see this true trons)				
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)  46.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N N N A6.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.  47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N A7.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N			V	XVIII	XIX	
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)  46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.  47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N			1. 00	2. 00	3.00	
with 42 CFR Section §412.320? (see instructions)  46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.  47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N		Prospective Payment System (PPS)-Capital				
46.00  Is this facility eligible for additional payment exception for extraordinary circumstances  Pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.  47.00  Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.  Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.  N N N N N N N N N N N N N N N N N N N	45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance	N	N	N	45.00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.  47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.  88.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.  89.00 Is this a hospital s  50.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.  57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		with 42 CFR Section §412.320? (see instructions)				1
Pt. III.  47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	46.00	Is this facility eligible for additional payment exception for extraordinary circumstances	N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.  Teaching Hospitals  56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.  57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through				1
48.00    Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.   N N N N N N N N N N N N N N N N N N N		Pt. III.				ĺ
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"N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.  57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		Teaching Hospitals				
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GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		Enter "Y" for yes; otherwise, enter "N" for no in column 2.				1
is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	57.00					57.00
for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						1
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						1
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defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						1
	58. 00					58.00
59.00   Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.   N     59.00						1
	59. 00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

Health Financial Systems Lafayette Region	onal Reha	abilitation Ho	ospi t	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	CN: 15-3042	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/16/2022 12:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3.00	
60.00 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 colis "Y", are you impacted by CR 11642 (or subsequent C	85? (se umn 1. CR) NAHE	ee If column 1	N N	2.00	3.00	60. 00
adjustement? Enter "Y" for yes or "N" for no in colu	y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5. 00	
61.00 Did your hospital receive FTE slots under ACA	1.00	2.00	3.00	0.00		61. 00
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Prog	gram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each expanded				0.00		61. 10
program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
					1.00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				riod for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruction 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	ctions) a Teachir gram. (se	ng Health Cent ee instruction	ter (THC) int			62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings o	during this co			N	63. 00
			Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base yea	2.00 ur is your cost r	3.00 reporting	
period that begins on or after July 1, 2009 and before 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty traine n-primary all nonp d non-pri n column	ed residents y care provider mary care 3 the ratio	0.	0. 00	0. 000000	64.00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-3042 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/16/2022 12:32 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

					6.5	0550 40	
	Financial Systems Lafayette Regional Rel L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/16/2022 12:	epared:	
					1. 00		
80.00	Long Term Care Hospital PPS s this a long term care hospital (LTCH)? Enter "Y" for yes s this a LTCH co-located within another hospital for part of Y" for yes and "N" for no.			g period? Enter	N N	80. 00 81. 00	
85. 00 86. 00	TEFRA Providers s this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (exclude				N	85. 00 86. 00	
87. 00	6413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. s this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified ι	under section		N	87. 00	
	rood(d)(1)(b)(v1): Enter 1 Tol yes of N Tol no.			V	XI X		
				1.00	2.00		
	Fitle V and XIX Services			1.00	2.00		
90. 00	obes this facility have title V and/or XIX inpatient hospitalized or "N" for no in the applicable column.	al services? Er	nter "Y" for	N	N	90.00	
91. 00	s this hospital reimbursed for title V and/or XIX through to full or in part? Enter "Y" for yes or "N" for no in the appl	N	N	91.00			
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dunstructions) Enter "Y" for yes or "N" for no in the applications of the control o	ual certificati			N	92. 00	
	Does this facility operate an ICF/IID facility for purposes Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00	
	Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N	N	94. 00	
95. 00 96. 00	5.00   Filine 94 is "Y", enter the reduction percentage in the applicable column. 0.00   0.00						
97. 00 98. 00							
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98. 01	
98. 02	citle XIX. Does title V or XIX follow Medicare (title XVIII) for the caped costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of the costs on Wkst. D-1, Pt. IV, line 89?			Y	Y	98. 02	
98. 03	For title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for yo For title V, and in column 2 for title XIX.				N	98. 03	
98. 04	on title V, and in Column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH Dutpatient services cost? Enter "Y" for yes or "N" for no in n column 2 for title XIX.			N	N	98. 04	
	obes title V or XIX follow Medicare (title XVIII) and add ba Vkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.				Y	98. 05	
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 06	
	Rural Providers						
106.00	Ooes this hospital qualify as a CAH? f this facility qualifies as a CAH, has it elected the all-	-inclusive meth	nod of paymen	t N		105. 00 106. 00	
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for co					107. 00	
	raining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded If	you train I&Rs PF and/or IRF υ	s in an				
108.00	Enter "Y" for yes or "N" for no in column 2. (see instructing sthis a rural hospital qualifying for an exception to the		dul e? See 42	N		108. 00	
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona		Respiratory		
100.00	f this bosnital qualifies as a CAH on a cost provider and	1. 00	2.00	3. 00	4.00	100.00	
	f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. 00	

	1.00	
110.00Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

ealth Financial Systems Lafayette Regional Rehabil OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA F	Provider CCI	_	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S- Part I Date/Time Pi 5/16/2022 12	-2 repared:
			1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the F Health Integration Project (FCHIP) demonstration for this cost r "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is partici Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services.	reporting pon n 1 is Y, en pating in o	eriod? Enter nter the column 2.	. N		111.0
	+	1. 00	2.00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Health M demonstration for any portion of the current cost reporting peri Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	od?	N	2.00	5. 00	112. 0
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" providers for short term hospital or "98" percent for long term care (inclusive psychiatric, rehabilitation and long term hospitals providers) by the definition in CMS Pub. 15-1, chapter 22, §2208.1.	E only) percent udes	N			0 115. 0
16.00 Is this facility classified as a referral center? Enter "Y" for "N" for no.	yes or	N			116. 0
17.00 s this facility legally-required to carry malpractice insurance	e? Enter	N			117. 0
"Y" for yes or "N" for no.  18.00 Is the malpractice insurance a claims-made or occurrence policy?  if the policy is claim-made. Enter 2 if the policy is occurrence			0		118. 0
		Premi ums	Losses	Insurance	
	+	1. 00	2.00	3.00	+
18.01 List amounts of malpractice premiums and paid losses:			0 (		0 118. C
			1. 00	2.00	+
18.02 Are malpractice premiums and paid losses reported in a cost cent Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE			N		118. (
20.00 ls this a SCH or EACH that qualifies for the Outpatient Hold Har §3121 and applicable amendments? (see instructions) Enter in col "N" for no. Is this a rural hospital with < 100 beds that qualif Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	umn 1, "Y" ies for th	for yes or e Outpatient		N	119. ( 120. (
21.00 Did this facility incur and report costs for high cost implantab	ole devices	charged to	N		121. (
patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.					122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for ye	es and "N"	for no. If	N		125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter			,		126. (
in column 1 and termination date, if applicable, in column 2.					
27.00  f this is a Medicare certified heart transplant center, enter t  in column 1 and termination date, if applicable, in column 2.					127. (
28.00 f this is a Medicare certified liver transplant center, enter t in column 1 and termination date, if applicable, in column 2.	the certifi	cation date			128. (
29.00 If this is a Medicare certified lung transplant center, enter th	ne certific	ation date i	n		129. (
		i fi cati on			130. (
	^	rtification			131. (
30.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column			1		
30.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 31.00 If this is a Medicare certified intestinal transplant center, er date in column 1 and termination date, if applicable, in column	nter the ce 2.				
30.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 31.00 If this is a Medicare certified intestinal transplant center, er	nter the ce 2.				
30.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 31.00 If this is a Medicare certified intestinal transplant center, er date in column 1 and termination date, if applicable, in column 32.00 If this is a Medicare certified islet transplant center, enter tin column 1 and termination date, if applicable, in column 2.	nter the ce 2. The certifi	cation date			132. 0 133. 0 134. 0

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-3042 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: To 12/31/2021 5/16/2022 12:32 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: FRNEST HEALTH LNC. Contractor's Name: NOVITAS SOLUTIONS Contractor's Number: 04011 141 00 142.00 Street: 4600 LENA DRIVE PO Box: 142.00 143.00 Ci ty: MECHANI CSBURG 17055 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? N 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 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) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

	FINANCIAL SYSTEMS LAFAYETTE REGIONAL REFINEURSEMENT QUESTIONNAIRE			Peri od: From 01/01/2021	Worksheet S-2 Part II	
				To 12/31/2021		
			I.	Y/N	Date	JZ piii
	Constant I and a series of the	l 6II NO	F-+-	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format.	i for all NO re	esponses. Ente	er all dates in t	ine	
	COMPLETED BY ALL HOSPITALS					
1.00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)		14.41	
			Y/N 1.00	2.00	V/I 3. 00	
2.00	Has the provider terminated participation in the Medicare F		N	2.00	0.00	2. 00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	mn 3, "V" for				
3.00	Is the provider involved in business transactions, includir		Y			3. 00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of	of the board				
	of directors through ownership, control, or family and other relationships? (see instructions)	er similar				
	rerationships: (see mistractions)		Y/N	Туре	Date	
	Financial Data and Danauta		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cert	tified Public	Υ	A		4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	allable in				
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
	To the second se			1. 00	2.00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column	2. If ves is	s the provider	· N	Ī	6.00
	is the legal operator of the program?	•	o the provider			
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during the	N N		7. 00 8. 00
	cost reporting period? If yes, see instructions.		J			
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10.00	Was an approved Intern and Resident GME program initiated of		the current	N		10. 00
	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I	. Pinan ∧n	nroved	N		11. 00
11 00		IN		11.00		
11. 00	Teaching Program on Worksheet A? If yes, see instructions.	α κ τη απ Αργ				
11. 00		актап ар			Y/N 1.00	
11. 00	Teaching Program on Worksheet A? If yes, see instructions.	α κ τη απ Αργ			Y/N 1.00	
12. 00	Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s, see instruc			1. 00 Y	12.00
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection provider's bad debt collec	s, see instruc		ost reporting	1.00	12.00
12. 00 13. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, lif line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments.	s, see instructoolicy change (	during this co		1. 00 Y	
12. 00 13. 00 14. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement	s, see instructoolicy change o	during this co	tructi ons.	1. 00 Y N	13. 00
12. 00 13. 00 14. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, lif line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments.	s, see instruction iconsider the second seco	during this co f yes, see ins yes, see inst rt A	tructions.	1.00  Y N N T B	13. 00
12. 00 13. 00 14. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement	s, see instructoolicy change cents waived? It ng period? If Par	during this configurers, see instance  yes, see instance  rt A  Date	ructions. Par	1.00  Y N N  T B Date	13. 00
12. 00 13. 00 14. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement	s, see instruction iconsider the second seco	during this co f yes, see ins yes, see inst rt A	tructions.	1.00  Y N N T B	13. 00
12. 00 13. 00 14. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement Did total beds available change from the prior cost reportion.  PS&R Data Was the cost report prepared using the PS&R Report only?	s, see instructoolicy change cents waived? It ng period? If Par	during this configurers, see instance  yes, see instance  rt A  Date	ructions. Par	1.00  Y N N  T B Date	13. 00
12. 00 13. 00 14. 00 15. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes if line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reportion.  PS&R Data	s, see instructionality change of the second instructional control of the second instruction of	during this co	ructi ons. Par Y/N 3.00	1.00  Y N N  N t B Date 4.00	13. 00 14. 00 15. 00
12. 00 13. 00 14. 00 15. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti  PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	s, see instructoolicy change dents waived? If  ng period? If  Pai  Y/N  1.00	during this co	ructi ons.  Par  Y/N  3.00	1.00  Y N N  N t B Date 4.00	13. 00 14. 00 15. 00 16. 00
12. 00 13. 00 14. 00 15. 00	Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payme Bed Complement  Did total beds available change from the prior cost reportion to the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)  Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	s, see instructionality change of the second instructional control of the second instruction of	during this co	ructi ons. Par Y/N 3.00	1.00  Y N N  N t B Date 4.00	13. 00 14. 00 15. 00
12. 00 13. 00 14. 00 15. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reportion of the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	s, see instructoolicy change dents waived? If  ng period? If  Pai  Y/N  1.00	during this co	ructi ons.  Par  Y/N  3.00	1.00  Y N N  N t B Date 4.00	13. 00 14. 00 15. 00 16. 00
12. 00 13. 00 14. 00 15. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement Did total beds available change from the prior cost reportion of the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	s, see instructoolicy change dents waived? If  ng period? If  Pai  Y/N  1.00	during this co	ructi ons.  Par  Y/N  3.00	1.00  Y N N  N t B Date 4.00	13. 00 14. 00 15. 00 16. 00

Ν

19.00

19.00

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.

If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der C	CN: 15-3042	Period: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time P 5/16/2022 1	repared:
		Descr	iption	Y/N	Y/N	
		(	0	1. 00	3. 00	
20. 00				N	N	20. 00
	Report data for Other? Describe the other adjustments:	) (A)		V (1)		
		Y/N	Date	Y/N	Date	
21 00	Was the east report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	IN		IN		21. 00
	Trees as the feet as the tractions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
22 00	Capi tal Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see		ala mada du	ning the cost		22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		23. 00			
24. 00	Were new leases and/or amendments to existing leases entere	ed into durina	this cost re	eportina period?		24. 00
	If yes, see instructions			, . J p		
25. 00	Have there been new capitalized leases entered into during	? If yes, see		25. 00		
	instructions.					
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	ne cost reporti	ng period? I	It yes, see		26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	a cost reportir	na neri od2 li	f vas submit		27. 00
27.00	copy.	e cost reportir	g perrou: 11	i yes, subiii t		27.00
	Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cost	t reporting		28. 00
	period? If yes, see instructions.					
29. 00	Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)		29. 00
20.00	treated as a funded depreciation account? If yes, see instr		dob+2 l£ vo.			20.00
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	arity with new	debt? IT yes	s, see		30.00
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If ve:	s. see		31.00
	instructions.			-,		
	Purchased Services					
32. 00			d through co	ontractual		32.00
22.00	arrangements with suppliers of services? If yes, see instru		.a +o oomno+i	itivo biddingo If		22.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	orred pertainir	g to competi	itive brading? II		33.00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar	rangement with	provi der-ba	ased physicians?		34.00
	If yes, see instructions.	3				
35. 00			ts with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		V (1)	5 .	
				Y/N 1. 00	Date	
	Home Office Costs			1.00	2. 00	
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 pr	repared by the	home office	?		37. 00
	If yes, see instructions.					
38. 00	If line 36 is yes , was the fiscal year end of the home off			f		38. 00
20.00	the provider? If yes, enter in column 2 the fiscal year end			_		20.00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	ents: IT yes	5,		39. 00
40. 00		home office?	If ves see			40.00
	instructions.	3.11001	,00, 000			1 .0. 00
		1.	00	2.	00	
	Cost Report Preparer Contact Information	h.		la		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	Mary		Pi tcock		41. 00
	respectively.					
	I OSPOSEI VOI Y.	L	LNO			II
42. 00	Enter the employer/company name of the cost report	ERNEST HEALTH		42.00		
42. 00	Enter the employer/company name of the cost report preparer.	ERNEST HEALTH	INC			42. 00
42. 00 43. 00	preparer.	903-588-0077	INC	marykay@ernestl	neal th. com	43.00

Heal th	Financial Systems	Lafayette Regional	Rehal	oilitation H	Hospi	it		In Lie	u of Form	CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEM	ENT QUESTIONNAIRE		Provider C	CCN:	15-3042		ri od:	Worksheet	S-2	
							Fr To	om 01/01/2021 12/31/2021	Part II	Dro	narod:
							10	12/31/2021	5/16/2022		
				3.	. 00						
	Cost Report Preparer Contact Informati	on									
	Enter the first name, last name and the			Reimbursen	ment	Anal yst					41. 00
	held by the cost report preparer in co	olumns 1, 2, and 3,									
	respecti vel y.										
42. 00	Enter the employer/company name of the	e cost report									42. 00
	preparer.										
43. 00	Enter the telephone number and email a										43. 00
	report preparer in columns 1 and 2, re	especti vel y.									

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3042

Peri od: Worksheet S-3 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/16/2022 12:32 pm I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 5.00 1.00 2.00 3.00 4.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 40 14, 600 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 40 14,600 0.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 40 14,600 0.00 0 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 44.00 0 0 0 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 101.00 0 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 26. 25 26.25 27.00 Total (sum of lines 14-26) 40 27.00 28.00 Observation Bed Days 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 32.00 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

Heal th FinancialSystemsLafayette RegionalRehabilitationHospitHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider CCN: 15-3042

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2021 | Part |
| To 12/31/2021 | Date/Time Prepared: | 5/16/2022 | 12:32 pm

						5/16/2022 12:	32 pm
		I/P Days	6 / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 922	78	8, 734			1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	1, 212	989				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	C	)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C	)		6. 00
7.00	Total Adults and Peds. (exclude observation	4, 922	78	8, 734			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9. 00 10. 00	CORONARY CARE UNIT						9. 00 10. 00
11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	4, 922	78	8, 734	0.00	88. 27	
15. 00	CAH visits	o	0	C			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	C	0.00	0.00	
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE		0		0.00	0.00	21. 00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0.00	0.00	22. 00 23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)			(			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	88. 27	27. 00
28. 00	Observation Bed Days		0	C	)		28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C			31.00
32. 00	Labor & delivery days (see instructions)	0	0	C			32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days	o					33. 00
	LTCH site neutral days and discharges	o					33. 01
	1	,		ı	1	1	

Heal th FinancialSystemsLafayette RegionalRehabilitationHospitHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider CCN: 15-3042 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared:

					12/31/2021	5/16/2022 12:	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12.00	13. 00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	343	5	578	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			73	57		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	343	5	578	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.00					21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
31. 00							31.00
32. 00	Labor & delivery days (see instructions)						
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			o			33. 00
	LTCH site neutral days and discharges			0			33. 00
33.01	LETON SITE NEUTRAL Mays and discharges	ı J		ı	I		33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-3042 Peri od: Worksheet A From 01/01/2021 12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm Cost Center Description Sal ari es 0ther Total (col. 1 Reclassi fi cati Recl assi fi ed + col. 2) ons (See A-6) Trial Balance (col. 3 +-col. 4) 1.00 2.00 3.00 4.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1,646,729 1, 646, 729 8, 985 1, 655, 714 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 283, 737 283, 737 228, 267 512,004 2.00 00300 OTHER CAP REL COSTS 237, 252 237 252 3.00 -237, 252 3 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 548, 827 752, 552 1, 301, 379 1, 301, 379 4.00 00500 ADMINISTRATIVE & GENERAL 0 5.00 1, 785, 588 1, 281, 585 3, 067, 173 3, 067, 173 5.00 00700 OPERATION OF PLANT 0 581, 994 501.433 581.994 7.00 80, 561 7.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 44, 227 44, 227 44, 227 8.00 9.00 00900 HOUSEKEEPI NG 112,075 46, 685 158, 760 0 158, 760 9.00 01000 DI ETARY 211, 783 194, 362 0 10.00 10.00 406, 145 406, 145 295, 995 295, 995 13.00 01300 NURSING ADMINISTRATION 271, 552 24, 443 0 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 35, 643 12,018 47, 661 47, 661 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 990, 097 0 3, 107, 640 30.00 1, 117, 543 3, 107, 640 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 58, 907 58, 907 -3, 699 55, 208 54.00 05700 CT SCAN 0 3, 699 57.00 57 00 3, 699 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 60.00 06000 LABORATORY 0 131, 982 131, 982 0 131, 982 60.00 06500 RESPIRATORY THERAPY 65.00 127, 797 44, 171 171, 968 171, 968 65.00 0 06600 PHYSI CAL THERAPY 609, 009 66.00 528 433 80, 576 44, 685 66 00 653, 694 67.00 06700 OCCUPATIONAL THERAPY 323, 299 171, 603 494, 902 137, 777 632, 679 67.00 144, 200 68.00 06800 SPEECH PATHOLOGY 16,068 160, 268 42, 974 203, 242 68.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 33, 068 136, 069 169 137 169, 137 71 00 O 73.00 07300 DRUGS CHARGED TO PATIENTS 121, 790 267, 227 389, 017 0 389, 017 73.00 74.00 07400 RENAL DIALYSIS 131, 638 131, 638 0 131, 638 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.00 0 60, 610 60, 610 60, 610 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 04951 OUTPATIENT THERAPY 218, 757 6, 679 225, 436 -225, 436 0 91.01 91.01 04950 OUTPATIENT WOUND CENTER 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 117, 00|06950| OTHER SPECIAL PURPOSE COST CENTERS 0 117, 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 6, 533, 470 7, 248, 096 13, 781, 566 13, 781, 566 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 194 00 07950 MARKETING 0 0 0 194.00 0 Λ 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 01 200.00 TOTAL (SUM OF LINES 118 through 199) 6, 533, 470 7, 248, 096 13, 781, 566 13, 781, 566 200. 00

Cost Center Description					5/16/2022 12: 32	
		Cost Center Description	Adjustments	Net Expenses		
SEMERAL SERVICE COST CENTERS   1.00   0.00   0.02		·	(See A-8) F	or Allocation		
1.00			6. 00	7. 00		
2.00   00200   CAP REL COSTS-MYBLE EQUIP   74,661   586,685   2.00   3.00   4.00   00400   CHIPE CAP REL COSTS   0 0 0 0 0   0.0						
3.00   00300   OTHER CAP REL COSTS   0   0   0   0   0   0   0   0   0	1.00	00100 CAP REL COSTS-BLDG & FIXT	19, 252	1, 674, 966	1	1.00
A. 00	2.00	00200 CAP REL COSTS-MVBLE EQUIP	74, 681	586, 685	2	2. 00
5.00   00500   ADMINISTRATIVE & GENERAL   849,013   3,916,186   7,00   00700   OPERATION OF PLANT   7,519   574,475   7,00   00700   OPERATION OF PLANT   7,519   574,475   8,00   00900   HOUSEVEEPING   0   158,760   9,00   00900   HOUSEVEEPING   7,000   00900   HOUSEVEEPING   10,000   158,760   9,00   00900   HOUSEVEEPING   10,000   10,000   DETARY   7,515   398,630   113,00   01300   NURSING ADMINISTRATION   0   295,995   13,300   01300   NURSING ADMINISTRATION   0   295,995   013,000   0000   MEDICAL RECORDS & LIBRARY   7-211   47,420   0   0   0   0   0   0   0   0   0	3.00	00300 OTHER CAP REL COSTS	0	0	3	3. 00
7. OO     00700   00700   00700   00FERATI ON OF PLANT     -7, 519   574, 475   8.0   0.0	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 514	1, 297, 865	4	4. 00
8. 00   00800   LAUNDRY & LINEN SERVICE   0   44, 227   9, 00   00900   HOUSEKEEPING   0   158, 760   9, 00   00900   HOUSEKEEPING   0   158, 760   9, 00   00900   HOUSEKEEPING   0   158, 760   10, 00   10, 00   13, 00   01300   NURSING ARMINI STRATION   0   295, 995   13, 00   01, 00   0	5.00	00500 ADMINISTRATIVE & GENERAL	849, 013	3, 916, 186	5	5. 00
9.00   00900   HOUSEKEEPING   0   155, 760   10, 00   100   10   100   1	7.00	00700 OPERATION OF PLANT	-7, 519	574, 475	7	7. 00
10.00   01000   015ARY	8.00	00800 LAUNDRY & LINEN SERVICE	O	44, 227	8	3. 00
13. 00   01500   NURSI NG ADMINI STRATI ON   0   295, 995   13. 00   01600   MEDI CAL RECORDS & LI BRARY   -241   47, 420   16. 00   17, 581   16. 00   18, 100   19, 100   19	9.00	00900 HOUSEKEEPI NG	O	158, 760	9	₹. 00
16.00     1000   10	10.00	01000 DI ETARY	-7, 515	398, 630	10	J. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS   3, 107, 581   30. 00   300. 00   300. ADULTS & PEDI ATRI CS   -59   3, 107, 581   30. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   584   LLED NIRSI NG FACILLITY   0   0   0   44. 00   46.	13.00	01300 NURSING ADMINISTRATION	0	295, 995	13	3. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS   3, 107, 581   30. 00   300. 00   300. ADULTS & PEDI ATRI CS   -59   3, 107, 581   30. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   44. 00   584   LLED NIRSI NG FACILLITY   0   0   0   44. 00   46.	16.00	01600 MEDICAL RECORDS & LIBRARY	-241	47, 420	16	5. 00
30.00   03000   ADULTS & PEDIATRICS   -59   3, 107, 581   0   044.00   Adv. O   Ad			<u> </u>			
44.00	30.00		-59	3, 107, 581	30	0. 00
ANCILLARY SERVICE COST CENTERS	44.00	04400 SKILLED NURSING FACILITY	o		44	4. 00
54. 00  55. 00  56. 00  57. 00  570. 05700 CT SCAN  0 0 3, 699  57. 00  60. 00						
57. 00   05700   CT SCAN   0   3,699   55.00   580.00   5	54.00		0	55, 208	54	4. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 00 060.00 06000 LABORATORY 00 131, 982 66. 00 66. 00 66. 00 66. 00 06500 RESPI RATORY THERAPY 00 171, 968 66. 00 66. 00 66. 00 06600 PHYSI CAL THERAPY 00 665. 00 06700 OCTUPATI ONAL THERAPY 00 6632, 679 67. 00 0700 OCTUPATI ONAL THERAPY 00 0632, 679 67. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS -18 169, 119 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 01 389, 017 73. 00 74. 00 07400 RENAL DI ALYSI S -95 131, 543 74. 00 76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 00 0100 OTHER ANCILLARY SERVICE COST CENTERS 01 0100 OTHER REI MBURSABLE COST CENTERS 01 0100 OTHER REI MBURSABLE COST CENTERS 01 0100 OTHER REI MBURSABLE COST CENTERS 01 0100 OTHER SPECIAL PURPOSE COST CENTERS 01 0118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 00 OTHER MEI MBURSABLE COST CENTERS 01 01940. 01 019200 PHYSI CI ANS' PRI VATE OFFI CES 01 01 010 OTHER MEI MBURSABLE COST CENTERS 01 01 010 OTHER SPECIAL PURPOSE COST CENTERS 01 01 01 010 OTHER SPECIAL PURPOSE COST CENTERS 01 01 01 010 OTHER SPECIAL PURPOSE COST CENTERS 01 01 01 010 OTHER SPECIAL PURPOSE COST CENTERS 01 01 01 010 OTHER SPECIAL PURPOSE COST CENTERS 01 01 01 01 01 010 OTHER SPECIAL PURPOSE COST CENTERS 01 01 01 01 01 01 01 01 01 01 01 01 01	57. 00		o			
60. 00 6000 LABORATORY 0 131, 982 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 1717, 968 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 653, 694 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 632, 679 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 203, 242 668. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS -18 169, 119 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 389, 017 73. 00 74. 00 07400 RENAL DI ALYSIS -95 131, 543 74. 00 76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 60, 610 76. 00 00TPATI ENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 9100 EMERGENCY 91. 01 04951 OUTPATI ENT WOUND CENTER 0 0 0 93. 00 04950 OUTPATI ENT WOUND CENTER 0 0 0 93. 00 04950 OUTPATI ENT WOUND CENTER 0 0 0 0 93. 00 04950 OUTPATI ENT WOUND CENTER 0 0 0 0 1010 HOME HEALTH AGENCY 0 0 0 1010 HOME HEALTH AGENCY 0 0 0 1010 OUTPATI ENT SERVICES 0 0 0 0 1010 OUTPATI ENT SERVICES 0 0 1010 OUTPATI ENT SERVICES 0 0 1010 OUTPATI ENT WOUND CENTER 0 0 0 0 1010 OUTPATI ENT WOUND CENTER 0 0 0 0 1010 OUTPATI ENT WOUND CENTER 0 0 0 0 1010 OUTPATI ENT WOUND CENTER 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 0 0 1010 OUTPATI ENT WOUND CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			o		58	3. 00
65. 00			o	131, 982		
66. 00   06600   PHYSI CAL THERAPY   0   653, 694   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0   632, 679   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   203, 242   68. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   -18   169, 119   71. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   389, 017   73. 00   74. 00   07400   RENAL DIALYSIS   -95   131, 543   74. 00   76. 00   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   60, 610   76. 00   0UTPATIENT SERVICE COST CENTERS   0   0   0   91. 01   04951   OUTPATIENT THERAPY   0   0   0   93. 00   04950   OUTPATIENT WOUND CENTER   0   0   0   95. 00   07100   MBULANCE SERVICES   0   0   0   101. 00   0100   HOME HEALTH AGENCY   0   0   0   101. 00   01010   HOME HEALTH AGENCY   0   0   0   101. 00   01010   HOME HEALTH AGENCY   0   0   0   101. 00   SUBTOTALS (SUM OF LINES 1 through 117)   923, 985   14, 705, 551   118. 00   101. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   194. 01   07950   MARKETI NG   0   0   194. 01   07950   MARKETI NG   NONREI MBURSABLE COST CENTERS   0   0   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS   0   0   194. 01   07950   MARKETI NG   NONREI MBURSABLE COST CENTERS   0   0   0   194. 01   07950   MARKETI NG   0   0   195. 00   0   0   0   195. 00   0   0   196. 00   00   00   197. 00   00			o			
67. 00 06700 OCCUPATI ONAL THERAPY 0 632, 679 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 203, 242 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS -18 169, 119 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 389, 017 73. 00 74. 00 07400 RENAL DI ALYSIS -95 131, 543 74. 00 76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 60, 610 76. 00  OUTPATI ENT SERVI CE COST CENTERS  91. 00 09100 EMERGENCY 0 0 0 91. 00 91. 01 04951 OUTPATI ENT THERAPY 0 0 0 0 91. 01 93. 00 04950 OUTPATI ENT WOUND CENTER 0 0 0 0 91. 01 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00  SPECIAL PURPOSE COST CENTERS  117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 118. 00  SUBTOTALS (SUM OF LINES 1 through 117) 923, 985 14, 705, 551 18. 00  NONNEE IMBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 194. 01 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 01 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 01 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 01			o			
68. 00 06800 SPEECH PATHOLOGY 0 203, 242 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS -18 169, 119 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 389, 017 73. 00 74. 00 07400 RENAL DIALYSIS -95 131, 543 74. 00 76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 60, 610 74. 00  0UTPATIENT SERVICE COST CENTERS 0 60, 610 91. 00 91. 00 09100 EMERGENCY 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 93. 00  OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 0 0 0 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 95. 00 110. 00 10100 HOME HEALTH AGENCY 0 0 0 110. 00  SPECIAL PURPOSE COST CENTERS  117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 117. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 923, 985 14, 705, 551 118. 00 192. 00 19200 PHYSI CIANS' PRIVATE OFFICES 0 0 0 194. 00 194. 00 07950 MARKETI NG 0 0 0 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 00			o			
71. 00			0			
73. 00			-18			
74. 00			1			
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 60, 610 76. 00  OUTPATI ENT SERVICE COST CENTERS  91. 00 09100 EMERGENCY 0 0 0 91. 00  93. 00 04951 OUTPATI ENT THERAPY 0 0 91. 01  93. 00 04950 OUTPATI ENT WOUND CENTER 0 0 93. 00  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 0 0 9500 AMBULANCE SERVICES 0 95. 00  101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00  SPECIAL PURPOSE COST CENTERS  117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117. 00  SUBTOTALS (SUM OF LINES 1 through 117) 923, 985 14, 705, 551 118. 00  NONREI MBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 194. 00 07950 MARKETI NG 0 0 0 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01			1			
OUTPATI ENT SERVI CE COST CENTERS   O   O   O   O			1			
91. 00			-1	22/212		
91. 01	91.00		0	0	91	1. 00
93. 00 04950 OUTPATIENT WOUND CENTER 0 0 0 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 923, 985 14, 705, 551 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 01 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 194. 01			1			
OTHER REIMBURSABLE COST CENTERS   O   O   O   O			1			
95. 00	70.00		9	<u> </u>	,,	,, 00
101. 00	95 00		0	0	95	5 00
SPECIAL PURPOSE COST CENTERS   117. 00   06950   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   117. 00			1			
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 0 118. 00 0 118. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			<u> </u>			00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   923, 985   14, 705, 551   118. 00   NONREI MBURSABLE COST CENTERS   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0 0 0 194. 00 194. 01 07950   MARKETI NG   0 0 0 194. 00 194. 01 07951   OTHER NONREI MBURSABLE COST CENTERS   0 0 0 194. 01	117 00		0	0	117	7 00
NONREI MBURSABLE COST CENTERS   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   194. 00   194. 00   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS   0   0   194. 01			J ~ J	- 1		
192. 00	1 10.00		725, 705	11,700,001		2. 00
194. 00   07950   MARKETI NG	192 00		n	0	193	2 00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 01				-1		
				0		
200.00   10 m. C. Lines 110 till dagn 177)   725,700  14,700,001			923 985	14 705 551		
	200.00	, 1.5 (56m of 21M25 116 th 54gh 177)	, ,25, ,65	11, 700, 001	200	00

Health Financial Systems	Lafayette Regional Rehab	oilitation Hospit	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS		Provider CCN: 15-3042	Peri od: From 01/01/2021	Worksheet A-6
			To 12/31/2021	Date/Time Prepared:

					5/16/2022 13	2:32 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5.00		
	A - RCLS PCT THERAPY					
1.00	OCCUPATI ONAL THERAPY	67.00	44, 387	4, 255		1. 00
2.00	SPEECH PATHOLOGY	68. 00	13, 845	1, 327		2. 00
	TOTALS		58, 232	5, 582		
	B - RCLS O/P THERAPY					
1.00	PHYSI CAL THERAPY	66.00	105, 285	3, 214		1. 00
2.00	OCCUPATI ONAL THERAPY	67.00	86, 494	2, 641		2. 00
3.00	SPEECH PATHOLOGY	68.00	26, 978	824		3. 00
	TOTALS		218, 757	6, 679		
	C - RCLS CT FROM RADIOLOGY					
1.00	CT SCAN	57.00	0	3, 699		1. 00
	TOTALS		0	3, 699		
500.00	Grand Total: Increases		276, 989	15, 960		500.00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-3042 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared:

						0 12/31/2021 Date/II 5/16/20	me Prepared: 122 12:32 pm
		Decreases					
	Cost Center	Li ne #	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	58, 232	5, 582	0		1. 00
2.00		0.00	0	0	0		2. 00
	TOTALS		58, 232	5, 582			
	B - RCLS O/P THERAPY						
1.00	OUTPATIENT THERAPY	91. 01	218, 757	6, 679	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0_	0	0		3. 00
	TOTALS		218, 757	6, 679			
	C - RCLS CT FROM RADIOLOGY						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 699	0		1. 00
	TOTALS		0	3, 699			
500.00	Grand Total: Decreases		276, 989	15, 960			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

| Period: | Worksheet A-7 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:

				1	0 12/31/2021	Date/lime Pre 5/16/2022 12:	
				Acqui si ti ons		07 107 2022 121	<u> </u>
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	0	0	0	0	0	
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	21, 647	75, 368	0	75, 368	l	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	20, 680	1, 200		1, 200	l	5. 00
6.00	Movable Equipment	2, 324, 835	695, 835	0	695, 835		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	772, 403	0	772, 403		8. 00
9.00	Reconciling Items	0	0	0	0	0	
10.00	Total (line 8 minus line 9)	2, 367, 162	772, 403	0	772, 403	0	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
		/ 00	Assets				
	DART I ANALYCIC OF CHANCEC IN CARLTAL ACCE	6. 00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES	0				1.00
		0	0				
2. 00 3. 00	Land Improvements	97, 015	0				2. 00 3. 00
4. 00	Buildings and Fixtures	97,015	0				4.00
5. 00	Building Improvements	21, 880	0				5.00
6. 00	Fi xed Equipment Movable Equipment	3, 020, 670	0				6.00
7. 00	HIT designated Assets	3,020,070	0				7.00
7. 00 8. 00	Subtotal (sum of lines 1-7)	3, 139, 565	0				8.00
9. 00		3, 139, 303	0				9.00
10.00	Reconciling Items Total (line 8 minus line 9)	3, 139, 565	0				10.00
10.00	Total (Tine o IIII lus Tine 7)	3, 137, 303	O <sub>l</sub>	I			1 10.00

Health Financial Systems	Lafayette Regional Rehabilitation Hospit	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-3042	Period: Worksheet A-7

SUMMARY OF CAPITAL Taxes (see instructions) Insurance (see Cost Center Description Depreciation Lease Interest instructions) 9.00 10.00 11.00 12.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0 CAP REL COSTS-BLDG & FIXT 8, 220 1, 608, 788 29, 721 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 40, 358 243, 379 0 0 2.00 1, 649, 146 3.00 Total (sum of lines 1-2) 251, 599 29, 721 0 3.00 SUMMARY OF CAPITAL Total (1) (sum Cost Center Description 0ther Capital-Relate of cols. 9 d Costs (see through 14) instructions) 14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FLXT 1, 646, 729 1.00 0 1.00 0 2.00 CAP REL COSTS-MVBLE EQUIP 283, 737 2.00 3.00 Total (sum of lines 1-2) 1, 930, 466 3.00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10							
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021	Worksheet A-7		
				Fo 12/31/2021	Part III Date/Time Pre 5/16/2022 12:	pared: 32 pm	
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
		Leases	for Ratio	instructions)			
			(col. 1 - col. 2)				
	1.00	2.00	3. 00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS C	NTERS						
1.00 CAP REL COSTS-BLDG & FLXT	118, 895		118, 89!				
2.00 CAP REL COSTS-MVBLE EQUIP	3, 020, 670		3, 020, 670			2. 00	
3.00 Total (sum of lines 1-2)	3, 139, 565		3, 139, 56!			3. 00	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Relate					
		d Costs	through 7)				
DART LLL DESCRIPTION OF CARLEY COOTS	6.00	7. 00	8. 00	9. 00	10. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CI		1 0	0.000	27 472	1 (00 700	1 00	
1.00 CAP REL COSTS-BLDG & FLXT	8, 111		8, 98!	1	,		
2.00 CAP REL COSTS-MVBLE EQUIP	206, 061		228, 26 237, 252	1			
3.00 Total (sum of lines 1-2)	214, 172		JMMARY OF CAPI		1, 649, 146	3.00	
Cost Center Description	Interest	Insurance (see	,		Total (2) (sum		
		instructions)	instructions)				
				d Costs (see	through 14)		
	11.00	10.00	40.00	instructions)	45.00		
PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12.00	13. 00	14. 00	15. 00		

29, 721

0 29, 721

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

0 0 0

1, 674, 966 586, 685 2, 261, 651

1.00

2. 00

8, 111 206, 061 214, 172

874

22, 206 23, 080

1.00

2.00

Peri od: Worksheet A-8 From 01/01/2021

12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -1, 354 ADMI NI STRATI VE & GENERAL 7.00 5.00 7.00 Α stations excluded) (chapter 8.00 Tel evi si on and radi o servi ce -6, 901 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 0 10.00 10.00 Provider-based physician A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 1, 160, 349 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -7, 515 DI ETARY 10.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 0 17.00 pati ents -241 MEDICAL RECORDS & LIBRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL 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) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 \*\*\* Cost Center Deleted \*\*\* 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29.00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0.00 Depreciation and Interest 33.00 INTEREST INCOME -453 ADMI NI STRATI VE & GENERAL В 5.00 0 33.00

Provider CCN: 15-3042 Peri od:

Worksheet A-8

From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					o 12/31/2021	Date/Time Pre 5/16/2022 12:	
				Expense Classification on	Worksheet A	3/10/2022 12.	32 piii
				To/From Which the Amount is			
				To the miner the time are is	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	'	1.00	2. 00	3.00	4. 00	5. 00	
33. 02	MI SC I NCOME	В	-13, 285	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 09	OTHER	A	-154	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
	EXPENSE-ADVERTI SI NG/MARKETI NG-						
33. 11	OTHER	A	-604	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
	EXPENSE-ADVERTI SI NG/MARKETI NG-						
33. 13	OTHER	A	-24, 836	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
	EXPENSE-ADVERTI SI NG/MARKETI NG-						
33. 29	BAD DEBT EXPENSE-BAD DEBT	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	00.27
33. 46	OTHER EXPENSE-CASH AWARDS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 46
33. 82	OTHER EXPENSE-CONTRIBUTIONS /	A	-500	ADMINISTRATIVE & GENERAL	5. 00	0	33. 82
	SPONSO						
33. 83	OTHER EXPENSE-CONTRIBUTIONS /	A	-7, 375	ADMINISTRATIVE & GENERAL	5. 00	0	33. 83
	SP0NS0						
33. 91	OTHER EXPENSE-FLOWERS &	A	-152	ADMINISTRATIVE & GENERAL	5. 00	0	33. 91
	GI FTS			l		_	
34. 09	OTHER EXPENSE-FLOWERS &	A	-59	ADULTS & PEDIATRICS	30.00	0	34. 09
24 17	GIFTS		217	ADMINISTRATIVE & CENEDAL	F 00	_	24 17
34. 17	TAXES-FRANCHI SE FEES/BUSI NESS	A	-216	ADMINISTRATIVE & GENERAL	5. 00	0	34. 17
24 21	TAX	_	424	ADMINISTRATIVE & CENEDAL	F 00	0	24 21
34. 21	OTHER EXPENSE GLYFAWAYS	A		ADMINISTRATIVE & GENERAL	5.00	0	•
34. 22	OTHER EXPENSE-GIVEAWAYS	A A	-	ADMINISTRATIVE & GENERAL	5.00	0	0
34. 24 34. 38	OTHER EXPENSE CLYEAWAYS	A	-	ADMINISTRATIVE & GENERAL	5.00	0	
34. 38	OTHER EXPENSE-GIVEAWAYS OTHER FEES-LATE FEES			ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	34. 38 34. 48
34. 48	OTHER FEES-LATE FEES	A A		OPERATION OF PLANT	7.00	0	ı
34. 03	OTHER FEES-LATE FEES	A		MEDICAL SUPPLIES CHARGED TO	71.00	0	•
34.77	OTHER FEES-LATE FEES	A	-10	PATIENTS	71.00	U	34.77
34. 81	OTHER FEES-LATE FEES	A	_95	RENAL DIALYSIS	74.00	0	34. 81
34. 93	TAXES-SALES TAX	A		ADMINISTRATIVE & GENERAL	5.00	0	0 0 .
34. 95	TAXES-USE TAX	A	-	ADMINISTRATIVE & GENERAL	5. 00	0	34. 95
35. 20	NON-OPERATING REALIZED	A	-	ADMINISTRATIVE & GENERAL	5. 00	0	35. 20
33. 20	GAI N/LOSS-NON		30, 000	ADMINISTRATIVE & GENERAL	3.00	0	33. 20
35. 23	MARKETING EXPENSE	A	-28 774	ADMINISTRATIVE & GENERAL	5. 00	0	35. 23
35. 24	MARKETING BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT		0	35. 24
35. 25	TELEPHONE OPERATOR EXPENSE	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	1
35. 26	TELEPHONE BENEFIT EXPENSE	A	•	EMPLOYEE BENEFITS DEPARTMENT		0	35. 26
35. 28	UNALLOWABLE LOBBYING % OF	A		ADMINISTRATIVE & GENERAL	5. 00	0	35. 28
	ASSOC DUES	''	., ., 0		3.00		
50.00	TOTAL (sum of lines 1 thru 49)		923, 985				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

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

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

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

Peri od: From 01/01/2021

			Го 12/31/2021 	Date/Time Pre 5/16/2022 12:		
Li ne 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 ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED						
HOME OFFICE COSTS:						
1. 00	CAP REL COSTS-BLDG & FIXT	HO Alloc - Cap Rel Bldg	19, 252	0	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	74, 681	0	2.00	
5. 00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1, 354, 057	0	3.00	
5. 00	ADMINISTRATIVE & GENERAL	Intercompany Management Fees	0	287, 641	4.00	
0		0	1, 447, 990	287, 641	5.00	
	1.00  COSTS INCURRED AND ADJUSTMOME OFFICE COSTS:  1.00 2.00 5.00 5.00	1.00 2.00  C. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS:  1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 5.00 ADMINISTRATIVE & GENERAL 5.00 ADMINISTRATIVE & GENERAL	1.00 2.00 3.00  COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED OR HOME OFFICE COSTS:  1.00 CAP REL COSTS-BLDG & FIXT HO ALLOC - Cap Rel Bldg HO ALLOC - Cap Rel Equipment 5.00 ADMINISTRATIVE & GENERAL HO ALLOC - Cap Rel A&G	Allowable Cost  1.00 2.00 3.00 4.00  COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS:  1.00 CAP REL COSTS-BLDG & FIXT HO Alloc - Cap Rel Bldg 2.00 CAP REL COSTS-MVBLE EQUIP HO Alloc - Cap Rel Equipment 74, 681 5.00 ADMINISTRATIVE & GENERAL HO Alloc - Cap Rel A&G 5.00 ADMINISTRATIVE & GENERAL Intercompany Management Fees 0 1, 447, 990	Li ne No.  Cost Center  Expense I tems  Amount of All owable Cost Included in Wks. A, column 5  COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED  1.00  COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED  1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 4.00 ADMINISTRATIVE & GENERAL 5.00 ADMINISTRATIVE & GENERAL 6.00 ADMINISTRATIVE & GENERAL 7.00 CAP REL COSTS-MVBLE EQUIP 8.00 ADMINISTRATIVE & GENERAL 9.00 ADMINISTRATIVE & GENERAL	

\* 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	
-3 (1)		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В		O. OO ERNEST HEALTH	H 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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th	Financial Syste	ems	Lafayette Regional	Rehabilitation Hospit	In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HO	OME Provider CCN: 15-3042	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2021 To 12/31/2021	Date/Time Pre	narod:
					10 12/31/2021	5/16/2022 12:	
	Net	Wkst. A-7 Ref.	·				
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	F TRANSACTIONS WITH RELATED	ORGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:					
1.00	19, 252	9					1. 00
2.00	74, 681	9					2. 00
3.00	1, 354, 057	0					3.00
4.00	-287, 641	0					4. 00
5.00	1, 160, 349						5. 00
* The	amounts on line	es 1-4 (and sub	oscripts as appropriate) are	transferred in detail to Woo	rksheet A, column	6, lines as	
appropr	i ate. Posi ti ve	amounts increas	se cost and negative amounts	decrease cost. For related or	rganization or hom	ne office cost	whi ch
has not	been posted to	o Worksheet A,	columns 1 and/or 2, the amou	unt allowable should be indic	cated in column 4	of this part.	
	Related Orga	ani zati on(s)					
	and/or Ho	me Office					

Related Organization(s)
and/or Home Office

Type of Business

6.00

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.

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10. 00
9. 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.
- 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.

					To 12/31/2021	Date/Time Pre	pared:
			CAPI TAL REL	_ATED COSTS		5/16/2022 12:	32 pm
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)	4.00	0.00	4.00	4.0	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	1, 674, 966	1, 674, 966				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	586, 685	1,074,700	586, 68	5		2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 297, 865	6, 691	2, 34			4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	3, 916, 186	111, 030			4, 456, 035	5. 00
7. 00	00700 OPERATION OF PLANT	574, 475	382, 507	133, 97		1, 108, 554	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	44, 227	002, 007	100, 77	0 .,,,,,,	44, 227	8. 00
9. 00	00900 HOUSEKEEPI NG	158, 760	10, 838	3. 79	6 24, 474	197, 868	9. 00
10.00	01000 DI ETARY	398, 630	152, 640	53, 46		650, 983	10.00
13. 00	01300 NURSING ADMINISTRATION	295, 995	17, 460	6, 11		378, 870	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	47, 420	18, 122	6, 34		79, 673	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·	·				
30.00	03000 ADULTS & PEDIATRICS	3, 107, 581	678, 725	237, 73	8 434, 588	4, 458, 632	30.00
44.00	04400 SKILLED NURSING FACILITY	o	0		o o	0	44.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	55, 208	0		0 0	55, 208	54.00
57. 00	05700 CT SCAN	3, 699	0		0 0	3, 699	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58. 00
60.00	06000 LABORATORY	131, 982	0		0 0	131, 982	60. 00
65. 00	06500 RESPI RATORY THERAPY	171, 968	6, 970	2, 44		209, 287	65. 00
66. 00	06600 PHYSI CAL THERAPY	653, 694	124, 552	43, 62		947, 544	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	632, 679	72, 278	25, 31		829, 455	67. 00
68. 00	06800 SPEECH PATHOLOGY	203, 242	7, 667	2, 68		253, 999	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	169, 119	16, 031	5, 61		197, 986	71.00
	07300 DRUGS CHARGED TO PATIENTS	389, 017	19, 516	6, 83		441, 965	73.00
74.00	07400 RENAL DIALYSIS	131, 543	0		0	131, 543	74.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	60, 610	0		0 0	60, 610	76. 00
91. 00	OUTPATIENT SERVICE COST CENTERS  09100 EMERGENCY	ol	0		ol ol	0	91.00
	04951 OUTPATIENT THERAPY		0			0	91.00
	04950 OUTPATIENT THERAPT		0			0	93.00
73.00	OTHER REIMBURSABLE COST CENTERS	l o	U		<u> </u>	0	73.00
95. 00	09500 AMBULANCE SERVICES	ol	0		ol ol	0	95. 00
	10100 HOME HEALTH AGENCY		0				101. 00
101.00	SPECIAL PURPOSE COST CENTERS	٩			91 91		1101.00
117. 00	06950 OTHER SPECIAL PURPOSE COST CENTERS	ol	0		ol ol	0	117. 00
118. 00		14, 705, 551	1, 625, 027	569, 19	1, 306, 900		
	NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	,			
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	49, 765	17, 43	1 0	67, 196	192. 00
194.00	07950 MARKETI NG	o	174	6	1 0	235	194. 00
194.01	07951 OTHER NONREIMBURSABLE COST CENTERS	o	0		0 0	0	194. 01
200.00						0	200. 00
201.00	Negative Cost Centers		0		0 0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	14, 705, 551	1, 674, 966	586, 68	5 1, 306, 900	14, 705, 551	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/16/2022	12:32 pm

						5/16/2022 12:	32 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	· ·	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 456, 035					5. 00
7. 00	00700 OPERATION OF PLANT	481, 951	1, 590, 505				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	19, 228	1, 370, 303	63, 455			8.00
9. 00	00900 HOUSEKEEPI NG	86, 024	14, 674	1	298, 566		9. 00
10.00	01000 DI ETARY	283, 019	206, 663			1, 179, 821	
	01300 NURSI NG ADMI NI STRATI ON		23, 639			1, 179, 621	13. 00
13.00		164, 716	· ·		4, 479		
16. 00		34, 638	24, 535	0	4, 649	0	16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 000 440	242.245		474 407	4 470 004	
30. 00		1, 938, 412	918, 945	1		1, 179, 821	
44. 00		0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
54. 00		24, 002	0	0	0	0	54.00
57.00		1, 608	0	0	0	0	57. 00
58. 00		0	0	0	0	0	58. 00
60.00		57, 380	0	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	90, 989	9, 437	0	1, 788	0	65. 00
66.00	06600 PHYSI CAL THERAPY	411, 950	168, 633	0	31, 950	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	360, 611	97, 858	0	18, 541	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	110, 428	10, 380	0	1, 967	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	86,076	21, 704	0	4, 112	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	192, 147	26, 423	0	5, 006	0	73. 00
74. 00		57, 189	0			0	74. 00
76. 00		26, 351	0	Ō	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS		-				1
91. 00		0	0	0	0	0	91.00
91. 01		ol	0	_	_	Ö	
93. 00	1 · · · · · · · · · · · · · · · · · · ·	Ö	0	_	_	0	
73.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1	<u> </u>	0	75.00
95 00	09500 AMBULANCE SERVI CES	O	0	0	0	0	95. 00
	0 10100 HOME HEALTH AGENCY		0		0		101. 00
101.0	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	U	U	101.00
117 0	0 06950 OTHER SPECIAL PURPOSE COST CENTERS	O		0	0	0	117. 00
117.0			1 500 001	1			
118.0	3 /	4, 426, 719	1, 522, 891	63, 455	285, 755	1, 179, 821	1118.00
400.0	NONREI MBURSABLE COST CENTERS	00.044	(7.070		40.7//		100 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	29, 214	67, 378		,		192. 00
	0 07950 MARKETI NG	102	236	0	45		194. 00
	1 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
200.0							200. 00
201. 0		0	0	1 0	0		201. 00
202. 0	0 TOTAL (sum lines 118 through 201)	4, 456, 035	1, 590, 505	63, 455	298, 566	1, 179, 821	202. 00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-3042 Peri od: Worksheet B From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm Cost Center Description NURSI NG MEDI CAL Subtotal Intern & Total RECORDS & ADMI NI STRATI ON Residents Cost LI BRARY & Post Stepdown Adjustments 13.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13.00 13 00 571, 704 01600 MEDICAL RECORDS & LIBRARY 16.00 143, 495 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 571, 704 63, 911 9, 368, 987 9, 368, 987 30.00 0 04400 SKILLED NURSING FACILITY 44 00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 1, 853 81, 063 81, 063 54.00 0 0 05700 CT SCAN 5, 431 57.00 57 00 124 5, 431 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 60.00 06000 LABORATORY 6, 047 195, 409 0 195, 409 60.00 0000000 06500 RESPIRATORY THERAPY 65.00 4, 945 316, 446 0 0 0 316, 446 65.00 1, 581, 953 06600 PHYSI CAL THERAPY 1, 581, 953 66.00 21, 876 66 00 06700 OCCUPATIONAL THERAPY 67.00 17, 972 1, 324, 437 1, 324, 437 67.00 06800 SPEECH PATHOLOGY 5, 606 382, 380 382, 380 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2, 164 312, 042 0 312, 042 71.00 07300 DRUGS CHARGED TO PATIENTS 16, 469 682,010 682, 010 73 00 73 00 74.00 07400 RENAL DIALYSIS 1,660 190, 392 190, 392 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 87, 829 87, 829 76.00 76.00 868 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 0 0 0 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 04950 OUTPATIENT WOUND CENTER 93.00 93.00 0 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 95 00 09500 AMBULANCE SERVICES 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117, 00 SUBTOTALS (SUM OF LINES 1 through 117) 14, 528, 379 14, 528, 379 118. 00 571, 704 143, 495 0 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 176, 554 192. 00 176, 554 0 618 194. 00 194. 00 07950 MARKETI NG 0 Λ 618

0

571, 704

0

143, 495

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14, 705, 551

0

0 194. 01

0 200. 00 0 201. 00

14, 705, 551 202. 00

200.00

201.00

202.00

194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

Health Financial Systems

Lafayette Regional Rehabilitation Hospit

In Lieu of Form CMS-2552-10

Provider CCN: 15-3042

Period: From 01/01/2021 To 12/31/2021

CAPITAL RELATED COSTS

Cost Center Description

Lafayette Regional Rehabilitation Hospit

Provider CCN: 15-3042

Period: From 01/01/2021 To 12/31/2021

CAPITAL RELATED COSTS

Cost Center Description

Directly BLDG & FIXT MVBLE EQUIP

Subtotal

EMPLOYEE

PRINTENTS

Cost Center Description							5/16/2022 12:	32 pm_
Assigned New   Capital   Related Costs   C				CAPI TAL REI	LATED COSTS			
Assigned New   Capital   Related Costs   C								
Capit Tale   Cap		Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
Related Costs   O								
CENERAL SERVICE COST CENTERS							DEPARTMENT	
ENERAL SERVICE COST CENTERS								
1.00			0	1.00	2.00	2A ]	4. 00	
2.00								
4.00   0.0400   EMPLOYEE BENEFITS DEPARTMENT   0   6.691   2.344   9.035   9.035   4.00     7.00   0.00700   0.00700   0.00700   0.00700   0.00700   0.00700     7.00   0.00700   0.00700   0.00700   0.00700   0.00700     8.00   0.00800   LAUINDRY & LINEN SERVICE   0   0   0   0   0   0     9.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0   0     9.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0   0     9.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0   0     9.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0   0     13.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0     13.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0     13.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0     13.00   0.00900   LAUINDRY & LINEN SERVICE   0   0   0   0   0   0     15.00900   LAUINDRY & LINEN SERVICE   0.00900   0   0   0   0   0     10.00   0.00900   LAUINDRY & LINEN SERVICE   0.00900   0   0   0   0   0     10.00   0.00900   LAUINDRY & LINEN SERVICE   0.00900   0   0   0   0   0   0     10.00   0.00900   LAUINDRY & LINEN SERVICE   0.00900   0   0   0   0   0   0     10.00   0.00900   LAUINDRY & LINEN SERVICE   0.00900   0   0   0   0   0   0   0   0								
5.00				, ,01	0.044	0.005	0.005	
7.00			0					
8. 00   00800   LAUINDRY & LINEN SERVICE			0				· ·	1
9,00   00900   HOUSEKEEPI NG			0					1
10. 00   01000   0157APY   0   152, 640   53, 465   206, 105   320   10. 00   13. 00   13. 00   01300   NURSI NG ADMINISTRATION   0   17, 460   6, 115   23, 575   410   13. 00   10.			0	J	-	~		1
13.00   01300 NURSING ADMINI STRATION   0   17, 460   6, 115   23, 575   410   13.00     16.00   1600 MEDICAL PECORDS & LIBRARY   0   18, 122   6, 347   24, 469   54     16.00   1000 MEDICAL PECORDS & LIBRARY   0   0   18, 122   6, 347   24, 469   54     16.00   1000 MEDICAL SERVICE COST CENTERS   0   678, 725   237, 738   916, 463   3, 003   30. 00     17.00   40.00   40.00   40.00   0   0   0   0   0   0     18.10   40.00   40.00   40.00   40.00   40.00   40.00     18.10   40.00   40.00   40.00   40.00   40.00   40.00   40.00     18.10   40.00   40			0		·			
16.00   01600   MEDICAL RECORDS & LIBRARY   0   18,122   6,347   24,469   54   16.00			0					
INPATIENT ROUTINE SERVICE COST CENTERS			0					1
30.00   03000   ADULTS & PEDI ATRICS   0   678, 725   237, 738   916, 463   3, 003   30.00   44.00   AUGADO SKI LLED NURSING FACILITY   0   0   0   0   0   0   44.00   AUGADO SKI LLED NURSING FACILITY   0   0   0   0   0   0   54.00   AUGADO SKI LLED NURSING FACILITY   0   0   0   0   0   0   55.00   57.00   CT SCAN   0   0   0   0   0   0   0   57.00   CT SCAN   0   0   0   0   0   0   0   0   57.00   CT SCAN   0   0   0   0   0   0   0   0   0	16.00		0	18, 122	6, 34/	24, 469	54	16.00
44. 00	00.00	INPATIENT ROUTINE SERVICE COST CENTERS		(70.705	007.700	047 479	2 222	00.00
ANCI LLARY SERVICE COST CENTERS			-				-	ł
54.00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   54.00	44.00		0	0	0	U	0	44.00
57.00   05700   CT SCAN   0   0   0   0   0   0   0   57.00	F4 00					ما	0	
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   0   0   0   0   0		1	0	_	_		_	
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			0	0		-		ł
65.00   06500   RESPI RATORY THERAPY   0   6,970   2,441   9,411   193   65.00   66.00   06600   06000   PHYSI CAL THERAPY   0   124,552   43,626   168,178   869   66.00   67.00   06700   06CUPATI ONAL THERAPY   0   72,278   25,316   97,594   686   67.00   68.00   06800   SPECH PATHOLOGY   0   7,667   2,685   10,352   279   68.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   16,031   5,615   21,646   50   71.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   19,516   6,836   26,352   184   73.00   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   76.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   76.00   07950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.00   007900   EMERGENCY   0   0   0   0   0   0   791.01   04951   OUTPATIENT THERAPY   0   0   0   0   0   0   791.01   04951   OUTPATIENT WOUND CENTER   0   0   0   0   0   792.00   04950   OUTPATIENT WOUND CENTER   0   0   0   0   0   793.00   04950   OUTPATIENT WOUND CENTER   0   0   0   0   795.00   09500   AMBULANCE SERVICES   0   0   0   0   0   795.00   05000   AMBULANCE SERVICES   0   0   0   0   0   79600   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   79600   OTHER REI MSURSABLE COST CENTERS   0   0   0   0   79600   OTHER REI MSURSABLE COST CENTERS   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   79600   OTHER RESPECIAL PURPOSE COST CENTER			0	0	_	ĭ	_	
66. 00   06600   PHYSI CAL THERAPY   0   124, 552   43, 626   168, 178   869   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   72, 278   25, 316   97, 594   686   67. 00   68. 00   06800   SPECI PATHOLOGY   0   0   74, 667   2, 685   10, 352   279   68. 00   0800   SPECI PATHOLOGY   0   77, 667   2, 685   10, 352   279   68. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   16, 031   5, 615   21, 646   50   71. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   19, 516   6, 836   26, 352   184   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0			0	4 070	1	ĭ		1
67. 00   06700   OCCUPATI ONAL THERAPY   0   72, 278   25, 316   97, 594   686   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   7, 667   2, 685   10, 352   279   68. 00   7000   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   16, 031   5, 615   21, 646   50   71. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   19, 516   6, 836   26, 352   184   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   76. 00   0950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   91. 00   00   0   0   0   0   0   91. 01   04951   OUTPATI ENT THERAPY   0   0   0   0   0   0   93. 00   04950   OUTPATI ENT WOUND CENTER   0   0   0   0   0   0   94. 01   04951   OUTPATI ENT WOUND CENTER   95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   117. 00   O6950   OTHER SPECIAL PURPOSE COST CENTERS   117. 00   06950   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   1, 625, 027   569, 193   2, 194, 220   9, 035   1194. 00   07950   MARKETING   0   49, 765   17, 431   67, 196   0   194. 00   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   0   0   200. 00   00   00   00   0   0   201. 00   Negative Cost Centers   0   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   0960   00   0   0   201. 00   0960   00   0   0   201. 00   0960   00   0   0   201. 00   0960   00   0   0   201. 00   0960   00   0   0   201. 00   0960   00   0   0   201. 00   0960   00   0   0   201. 00   0960   00   0   0   201. 00   0960   00   00   0   201. 00   0960   00   0   201. 00   0960   0960   0960   00   00   201. 00			0		·			
68. 00   06800   SPEECH PATHOLOGY   0   7, 667   2, 685   10, 352   279   68. 00   71. 00   71. 00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   16, 031   5, 615   21, 646   50   71. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74.			0		·			
71. 00			0					•
73. 00			0					
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   74. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0    91. 00   09100   EMERGENCY   0   0   0   0   0   0    91. 01   04951   OUTPATI ENT THERAPY   0   0   0   0   0   0    93. 00   04950   OUTPATI ENT WOUND CENTER   0   0   0   0   0    0   0   0   0			0		·			
76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 00 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		07400 DENAL DIALVSIS	0					
91. 00			0		-			
91. 00	70.00		U	0	U	<u> </u>	U	70.00
91. 01	01 00		0	0		٥	0	01 00
93. 00			_	-				
OTHER REIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O								
95. 00	73.00	OTHER RELIMBURSABLE COST CENTERS			<u> </u>	<u> </u>	0	75.00
101.00   10100   HOME HEALTH AGENCY   0   0   0   0   0   101.00	95 00		0	0	0	٥	0	95.00
SPECIAL PURPOSE COST CENTERS   117. 00   06950   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0   0   117. 00								
117. 00	101.00				<u> </u>	<u></u>		1101.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   0   1,625,027   569,193   2,194,220   9,035   118.00	117 00		0	0	0	٥	0	117 00
NONREI MBURSABLE COST CENTERS   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   49, 765   17, 431   67, 196   0   192. 00								
192. 00	110.00	1 2 2 2 7		1,020,027	007, 170	2, 171, 220	7,000	1110.00
194. 00 07950 MARKETING 0 174 61 235 0 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194. 01 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 201. 00	192 00		0	49 765	17 431	67 196	0	192 00
194. 01     07951     OTHER NONREIMBURSABLE COST CENTERS     0     0     0     0     194. 01       200. 00     Cross Foot Adjustments     0     0     0     0     0     0       201. 00     Negative Cost Centers     0     0     0     0     0     0			, o					
200.00     Cross Foot Adjustments     0     200.00       201.00     Negative Cost Centers     0     0     0			l ő					
201.00   Negative Cost Centers   0 0 0 0 201.00						ol Ol		
		1		o	0	ol	0	
1 1 2 2 2 2 3 1 3 1 3 1 3 1 3 1 3 1 3 1			o	1, 674, 966	-	2, 261, 651		
			. '					•

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Lafayette Regional Rehabilitation Hospit
Provider CCN: 15-3042

				1	0 12/31/2021	5/16/2022 12:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	JZ piii
		& GENERAL	PLANT	LINEN SERVICE			
		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 ADMINISTRATIVE & GENERAL	152, 616					5. 00
7.00	00700 OPERATION OF PLANT	16, 506	533, 114				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	659	0	659			8. 00
9.00	00900 HOUSEKEEPI NG	2, 946	4, 919	0	22, 668		9. 00
10.00	01000 DI ETARY	9, 693	69, 271	0	2, 973	288, 362	10.00
13.00	01300 NURSING ADMINISTRATION	5, 641	7, 923	0	340	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 186	8, 224	0	353	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	66, 391	308, 016	659	13, 219	288, 362	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	822	0	0	0	0	54.00
57.00	05700 CT SCAN	55	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	1, 965	0	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	3, 116	3, 163	0	136	0	65. 00
66.00	06600 PHYSI CAL THERAPY	14, 109	56, 523	0	2, 426	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	12, 351	32, 801	0	1, 408	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 782	3, 479	0	149	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 948	7, 275	0	312	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 581	8, 857	0	380	0	73. 00
74.00	07400 RENAL DIALYSIS	1, 959	0	0	0	0	74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	902	0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0		0	0	
91. 01	04951 OUTPATI ENT THERAPY	0	0		0	0	
93. 00	04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	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		117. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	151, 612	510, 451	659	21, 696	288, 362	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	1, 001	22, 584		969		192. 00
	07950 MARKETI NG	3	79		3		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	152, 616	533, 114	659	22, 668	288, 362	202.00

Health Financial Systems In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-3042 Peri od: Worksheet B From 01/01/2021 Part II 12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm Cost Center Description NURSI NG MEDI CAL Subtotal Intern & Total RECORDS & ADMI NI STRATI ON Residents Cost LI BRARY & Post Stepdown Adjustments 13.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13.00 13 00 37 889 01600 MEDICAL RECORDS & LIBRARY 16.00 34, 286 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 37, 889 15, 275 1, 649, 277 1, 649, 277 30.00 0 04400 SKILLED NURSING FACILITY 44.00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 443 1, 265 1, 265 54.00 0 0 05700 CT SCAN 57.00 57 00 30 85 85 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) C 0 0 58.00 60.00 06000 LABORATORY 1, 445 3, 410 0 3, 410 60.00 0000000 06500 RESPIRATORY THERAPY 65.00 1, 181 17, 200 0 0 0 17, 200 65.00 66.00 06600 PHYSI CAL THERAPY 5, 226 247, 331 247, 331 66 00 06700 OCCUPATIONAL THERAPY 67.00 4, 293 149, 133 149, 133 67.00 1, 339 06800 SPEECH PATHOLOGY 19, 380 19, 380 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 517 32, 748 0 32, 748 71.00 07300 DRUGS CHARGED TO PATIENTS 3, 934 46, 288 46, 288 73 00 73 00 07400 RENAL DIALYSIS 74.00 396 2, 355 2, 355 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 207 1, 109 1, 109 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 Ω 0 0 0 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 04950 OUTPATIENT WOUND CENTER 0 93.00 93.00 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 0 117, 00 2, 169, 581 2, 169, 581 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 37, 889 34, 286 0 118.00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 91, 750 91, 750 192. 00 0 320 194. 00 194. 00 07950 MARKETI NG 0 Λ 320 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 01 200.00 Cross Foot Adjustments 0 0 200.00 0 201.00 201.00 Negative Cost Centers 0 37, 889 202.00 TOTAL (sum lines 118 through 201) 34, 286 2, 261, 651 2, 261, 651 202. 00

In Lieu of Form CMS-2552-10
Worksheet B-1 | Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

COST Center Description					Т	o 12/31/2021	Date/Time Pre 5/16/2022 12:	
CENERAL SERVICE COST CENTERS   1.00   2.00   4.00   5.0			CAPITAL REL	ATED COSTS			37 107 2022 12.	JZ piii
CEMBERAL SERVICE COST CENTERS   1.00   2.00   4.00   5A   5.00   1.00		Cost Center Description			BENEFITS	Reconciliation	& GENERAL	
CENERAL SERVICE COST CENTERS   1.00   2.00   4.00   5A   5.00					(GROSS		(ACCUM. COST)	
1,00			1.00	2.00		5A	5. 00	
0.0200 CAP PEC COSTS-MVBLE COUP   48,0 63		GENERAL SERVICE COST CENTERS						
0.000   0.0000   EMPLOYEE BENEFITS DEPARTMENT   192   192   5, 984, 642   7, 805   10, 249, 116   5.00   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000			48, 063					
5.00   OSCOOL ADMINISTRATIVE & GENERAL   3, 186   2, 186   1, 785, 887   -4, 456, 035   10, 249, 516   5, 00				1				1
0.00   00700   DEFART   10.976   10.976   80.561   0   1.108,554   7.00   0.00   0   0   44,227   8.00   0.00			1	l				
0.00    0.00000   LAUNDRY & LINEN SERVICE   0   0   0   44, 227   8. 00   0.00   0.0000   HOUSEKEEPING   0.311   3.311   112, 075   0.197, 868   9. 00   0.000   0.10000   DIETARY   4. 380   4. 380   211, 783   0. 650, 983   10. 00   10. 00   0.000   NURSI NG ADMINI STRATI ON   550   550   271, 552   0. 378, 870   13. 00   13. 00   1300   NURSI NG ADMINI STRATI ON   550   520   35, 643   0. 79, 673   16. 00   NORTH PROPERTY NORTH PROPER					,	-4, 456, 035		1
9.00   000000  HOUSEKEPING   311   311   112,075   0   197,968   9.00   130   00000  BETARY   4,380   41,380   41,783   0   650,983   10.00   130   000   MEDICAL RECORDS & LIBRARY   520   520   35,643   0   79,673   13.00   130   000   MEDICAL RECORDS & LIBRARY   520   520   35,643   0   79,673   13.00   130   000   000   000   000   0   0   0		00700 OPERATION OF PLANT	10, 976	10, 976	80, 561	0		1
10. 00   010000   DIETARY			0	0	112.075	0		1
13. 00   01300   MUSIN GADMINISTRATION   501   501   271, 552   0   378, 870   13. 00		1						1
10. 00   0.1000   MEDICAL RECORDS & LIBRARY   5.00   5.00   35, 643   0   79, 673   10. 00		1		l ·				1
INPATIENT ROUTINE SERVICE COST CENTERS   19,476   1,9476   1,990,097   0   4,458,632   30.00   0   0   0   0   0   0   4,458,632   30.00   0   0   0   0   0   0   0   4,458,632   30.00   0   0   0   0   0   0   0   0   0		1	1	l e				1
30.00   03000   ADULTS & PEDI ATRIC S   19,476   19,476   1,990.07   0   4,488,632   30.00	10.00		520	520	30, 043	U	19,013	10.00
Add   Add   SAC   LEED NURSING FACILITY	30 00		19 476	19 476	1 990 097	0	4 458 632	30 00
ANCILLARY SERVICE COST CENTERS			1	1			.,	1
S4. 00   05400   RADI DLOGY-DI AGNOSTIC   0 0 0 0 0 3.6, 99   57. 00   57.00	44.00			0		0	0	44.00
57.00   05700   CT SCAN   0   0   0   0   0   0   0   0   0	54 00		0	0	0	0	55 208	54 00
S8.00   OSBOO MAGNETI C RESONANCE IMAGING (MRI)   0   0   0   0   0   0   0   0   0		1	0	0		0		1
60.00   0.0000   LABORATORY   Co.   0		1	0	0	0	0		
65.00   06500   RESPIRATORY THERAPY   200   200   127,797   0   209,287   65.00   66.0			0	0	0	0	-	1
66.00   06600   PMSI CAL THERAPY   3,574   3,574   575,485   0   947,544   66.00   67.00   06700   0CCUPATIONAL THERAPY   2,074   2,074   454,180   0   829,455   67.00   68.00   06800   SPEECH PATHOLOGY   220   220   185,024   0   253,999   68.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   460   460   33,068   0   197,986   71.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   560   560   121,790   0   441,965   73.00   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   131,543   74.00   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0   75.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0   75.00   07400   RENGEROY   0   0   0   0   0   0   0   0   0   75.00   07400   07400   07400   0   0   0   0   0   0   0   0   75.00   07400   07400   07400   07400   0   0   0   0   0   0   0   75.00   07400   07400   07400   07400   07400   0   0   0   0   0   0   75.00   07400   07400   07400   07400   07400   07400   0   0   0   0   0   0   0   0   0			200	200	127, 797	0		1
67.00   06700   06700   0600   0700   06000   0   0   253,999   68.00   068000   06800   06800   06800   06800   06800			1	l				1
171.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   460   460   33,068   0   197,986   71.00   73.00   07300   DRUGS CHARGED TO PATIENTS   560   560   121,790   0   441,965   73.00   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   131,543   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   0   0	67.00	06700 OCCUPATI ONAL THERAPY				0		
73.00   07300   DRUGS CHARGED TO PATIENTS   560   560   121,790   0   441,965   73.00   74.00   07400   RENAL DIALYSIS   0 0 0 0 0 0   0   131,543   74.00   76.00   03950   OTHER ANCILLARY SERVICE COST CENTERS   0 0 0 0 0   0   60,610   791.00   OUTPATIENT SERVICE COST CENTERS   0 0 0 0 0 0 0   0   91.00   91.01   04951   OUTPATIENT THERAPY   0 0 0 0 0 0 0 0   0 91.01   93.00   04950   OUTPATIENT WOUND CENTER   0 0 0 0 0 0 0 0   91.01   93.00   04950   OUTPATIENT WOUND CENTER   0 0 0 0 0 0 0 0 0   93.00   00   04950   OUTPATIENT WOUND CENTER   0 0 0 0 0 0 0 0 0   93.00   00   0500   AMBULANCE SERVICES   0 0 0 0 0 0 0 0 0 0   0 0   010.00   OUTPATIENT AGENCY   0 0 0 0 0 0 0 0 0   0 0   010.00   OUTPATIENT WOUND CENTERS   0 0 0 0 0 0 0 0 0   0 0   010.00   OUTPATIENT WOUND CENTERS   0 0 0 0 0 0 0 0 0   0 0   010.00   OUTPATIENT WOUND CENTERS   0 0 0 0 0 0 0 0 0   0 0   010.00   OUTPATIENT WOUND CENTERS   0 0 0 0 0 0 0 0 0   0 0   010.00   OUTPATIENT WOUND CENTERS   0 0 0 0 0 0 0 0 0   0 0   0 0   010.00   OUTPATIENT THERAPY   0 0 0 0 0 0 0 0 0 0 0   0 0 0   010.00   OUTPATIENT WOUND CENTERS   0 0 0 0 0 0 0 0 0 0   0 0 0   0 0   010.00   OUTPATIENT WOUND CENTERS   0 0 0 0 0 0 0 0 0 0   0 0 0   0 0 0   0 0   010.00   OUTPATIENT THERAPY   0 0 0 0 0 0 0 0 0 0   0 0 0   0 0   0 0   010.00   OUTPATIENT THERAPY   0 0 0 0 0 0 0 0 0 0   0 0 0   0 0   0 0   0 0   010.00   OUTPATIENT THERAPY   0 0 0 0 0 0 0 0 0 0 0   0 0 0   0 0   0 0   0 0   0 0   010.00   OUTPATIENT THERAPY   0 0 0 0 0 0 0 0 0 0   0 0 0   0 0	68. 00			1				1
74. 00   07400   REMAL DI ALYSIS   0   0   0   0   0   131, 543   74. 00   76. 00   03950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   60. 610   76. 00   00   00   0   0   0   0   0   0	71.00			l				1
76. 00   03950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0	73.00	07300 DRUGS CHARGED TO PATIENTS	560	560	121, 790	0	441, 965	73. 00
OUTPATIENT SERVICE COST CENTERS	74.00	07400 RENAL DIALYSIS	0	0	0	0	131, 543	74.00
91.00   09100   EMERGENCY   0   0   0   0   0   0   0   0   0	76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	60, 610	76. 00
91. 01 04951 OUTPATIENT THERAPY 0 0 0 0 0 0 0 0 91. 01 93. 00 04950 OUTPATIENT WOUND CENTER 0 0 0 0 0 0 0 0 93. 00  OTHER REIMBURSABLE COST CENTERS  117. 00 10100   home Health Agency 0 0 0 0 0 0 0 0 0 0 0 101. 00  SPECIAL PURPOSE COST CENTERS  117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS  118. 00 NOREI MBURSABLE COST CENTERS  1192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1, 428 1, 428 0 0 0 10, 182, 085 118. 00  194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 114. 01  200. 00 17950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		OUTPATIENT SERVICE COST CENTERS						
93. 00 04950   OUTPATI ENT WOUND CENTER   O   O   O   O   O   O   O   O   O			0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O		1	0	0	0	0	0	1
95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   0   0	93.00		0	0	0	0	0	93. 00
101.00   10100   HOME HEALTH AGENCY   0   0   0   0   0   101.00								1
SPECIAL PURPOSE COST CENTERS		1						
117. 00	101.00		0	0	0	0	0	101.00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   46,630   46,630   5,984,642   -4,456,035   10,182,085   118. 00	447.00					1		
NONREI MBURSABLE COST CENTERS   1,428   1,428   0   0   67,196   192.00			-		·	_	_	1
192. 00	118. UC	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	46, 630	46, 630	5, 984, 642	-4, 456, 035	10, 182, 085	]118.00
194. 00 07950   MARKETING   194. 01	102.00		1 /20	1 /20			67 106	102 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS			1,428	1,428				
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D,  207.00  Cross Foot Adjustments 200.00 201.00 201.00 201.00 202.00 201.00 201.00 202.00 201.00 202.00 201.00 202.00 203.00 204.00 205.00 206.00 206.00 206.00 206.00 207.00			7	, ,				1
201.00 202.00   Negative Cost Centers   201.00   202.00   Cost to be allocated (per Wkst. B, Part I)   34.849385   12.206583   1,306,900   4,456,035   202.00   203.00   204.00   Cost to be allocated (per Wkst. B, Part II)   205.00   Unit cost multiplier (Wkst. B, Part II)   206.00   NAHE adjustment amount to be allocated (per Wkst. B, Part II)   206.00   NAHE unit cost multiplier (Wkst. D, Part II)   207.00   NAHE unit cost multiplier (Wkst. D, Part III)   207.00   NAHE unit cost multiplier (Wkst. D, Part III)   207.00   NAHE unit cost multiplier (Wkst. D, Part III)   207.00   207.		1	0	0	٥		U	1
202.00   Cost to be allocated (per Wkst. B, Part I)   34.849385   12.206583   0.218376   0.434756   203.00   204.00   Cost to be allocated (per Wkst. B, Part II)   205.00   Unit cost multiplier (Wkst. B, Part II)   206.00   NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 207.00   NAHE unit cost multiplier (Wkst. D, 207.00   207.0		, ,						1
Part   1			1 674 966	586 685	1 306 900		4 456 035	
203.00 Unit cost multiplier (Wkst. B, Part I) 34.849385 12.206583 0.218376 0.434756 203.00 (204.00 Part II) 0.001510 152,616 204.00 Unit cost multiplier (Wkst. B, Part II) 0.001510 0.014890 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	202.00		1,071,700	000,000	1, 000, 700		1, 100, 000	202.00
204.00   Cost to be allocated (per Wkst. B, Part II)   0.001510   0.014890   205.00   Unit cost multiplier (Wkst. B, Part II)   0.001510   0.014890   205.00   10.001510   0.014890   206.00   206.00   206.00   206.00   NAHE adjustment amount to be allocated (per Wkst. B-2)   NAHE unit cost multiplier (Wkst. D, 207.00   207.00	203.00		34, 849385	12, 206583	0. 218376		0. 434756	203. 00
Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00								1
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	30							
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	205.00	1 /			0. 001510		0. 014890	205.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00								
207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206.00							206. 00
Parts   II   and   IV)	207.00							207. 00
			I	I	I		I	I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

| Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

			Т	o 12/31/2021	Date/Time Pre	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/16/2022 12: NURSI NG	32 piii
2001 2011101 20001   ptroii	PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT		
	(SQUARE FEET)	(TOTAL PATIENT		DAYS)		
		DAYS)			(NURSI NG	
	7.00	0.00	0.00	10.00	SALARI ES)	
GENERAL SERVI CE COST CENTERS	7. 00	8. 00	9. 00	10.00	13. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT			I			1.00
2. 00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT	33, 709					7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	0	8, 734				8. 00
9. 00 00900 HOUSEKEEPI NG	311	0	1,			9. 00
10. 00   01000   DI ETARY	4, 380	0	4, 380		4 000 007	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	501	0	501		1, 990, 097	13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	520	0	520	l O	0	16. 00
30. 00 03000 ADULTS & PEDI ATRI CS	19, 476	8, 734	19, 476	8, 734	1, 990, 097	30. 00
44. 00 04400 SKI LLED NURSING FACILITY	17, 470				0	44. 00
ANCI LLARY SERVI CE COST CENTERS				<u> </u>		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	О	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (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	200	0	200		0	65. 00
66. 00   06600   PHYSI CAL THERAPY	3, 574	0	3, 574		0	66.00
67. 00   06700 OCCUPATI ONAL THERAPY 68. 00   06800 SPEECH PATHOLOGY	2,074	0	2, 074	l .	0	67.00
68.00   06800   SPEECH PATHOLOGY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	220 460		220 460	l .	0	68. 00 71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	560		560		0	73. 00
74. 00   07400   RENAL DI ALYSI S	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	91. 00
91. 01   04951   OUTPATI ENT THERAPY	0	l e			0	91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS  95.00 O9500 AMBULANCE SERVICES	0	0	0	ol	0	95. 00
101. 00 10100 HOME HEALTH AGENCY		l e				101.00
SPECIAL PURPOSE COST CENTERS				١		101.00
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	32, 276	8, 734	31, 965	8, 734	1, 990, 097	118. 00
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 428	0	1, 428	0		192. 00
194. 00 07950 MARKETI NG	5	0	5	0		194. 00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS 200.00 Cross Foot Adjustments	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 590, 505	63, 455	298, 566	1, 179, 821	571, 704	
Part I)	1,370,303	03, 433	270, 300	1, 177, 021	371,704	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	47. 183393	7. 265285	8. 939637	135. 083696	0. 287274	
204.00 Cost to be allocated (per Wkst. B,	533, 114			I	37, 889	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	15. 815183	0. 075452	0. 678723	33. 016029	0. 019039	205. 00
NAME adjustment amount to be all asseted						204 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						
				·		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3042 Peri od: Worksheet B-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13 00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 20, 128, 865 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 965, 635 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 259, 871 54.00 57. 00 05700 CT SCAN 57.00 17, 414 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 60.00 06000 LABORATORY 848, 263 60.00 65. 00 06500 RESPIRATORY THERAPY 693, 661 65.00 66. 00 06600 PHYSI CAL THERAPY 66.00 3, 068, 620 06700 OCCUPATIONAL THERAPY 67.00 2, 520, 940 67.00 68.00 06800 SPEECH PATHOLOGY 786, 315 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 303, 488 71.00 07300 DRUGS CHARGED TO PATIENTS 2, 310, 102 73.00 73 00 74.00 07400 RENAL DIALYSIS 232, 800 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 121, 756 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 91.00 0 91.01 04951 OUTPATIENT THERAPY 0 91.01 04950 OUTPATIENT WOUND CENTER 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95 00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 117.00 20, 128, 865 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 194. 00 194. 00 07950 MARKETI NG 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 194. 01 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 143, 495 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.007129 203. 00 204.00 Cost to be allocated (per Wkst. B, 34, 286 204.00 Part II) Unit cost multiplier (Wkst. B, Part 205.00 0.001703 205. 00 H) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00 207.00

Parts III and IV)

near til Filialici ar Systellis Laraye	tte kegional ke	mabilitation n	uspi t	III LI E	u or Form CM3	2332-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	
					5/16/2022 12:	32 pm_
		litle	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	9, 368, 987		9, 368, 98	7 0	9, 368, 987	30.00
44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
ANCILLARY SERVICE COST CENTERS						1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	81, 063		81, 06	3 0	81, 063	54.00
57. 00 05700 CT SCAN	5, 431		5, 43	1 0	5, 431	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58. 00
60. 00 06000 LABORATORY	195, 409		195, 40	9 0	195, 409	60.00
65. 00 06500 RESPIRATORY THERAPY	316, 446	l o	316, 44	6 0	316, 446	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 581, 953		1, 581, 95	3 0	1, 581, 953	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 324, 437		1, 324, 43		1, 324, 437	
68. 00 06800 SPEECH PATHOLOGY	382, 380		382, 38		382, 380	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	312, 042	l e	312, 04		312, 042	
73. 00 07300 DRUGS CHARGED TO PATIENTS	682, 010		682, 01		682, 010	
74. 00   07400   RENAL DI ALYSI S	190, 392		190, 39		190, 392	
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	87, 829		87, 82		87, 829	
OUTPATIENT SERVICE COST CENTERS	07,027		07,02	.7	07,027	70.00
91. 00 09100 EMERGENCY	0			0	0	91. 00
91. 01   04951   OUTPATI ENT THERAPY	0			0	0	91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	0				0	93. 00
OTHER REIMBURSABLE COST CENTERS				9	0	75.00
95. 00 09500 AMBULANCE SERVI CES	0			0 0	0	95. 00
101. 00 10100 HOME HEALTH AGENCY	0	l		0	_	101. 00
SPECIAL PURPOSE COST CENTERS				U <sub>I</sub>	U	1101.00
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS					0	117. 00
200. 00 Subtotal (see instructions)	14, 528, 379	_	14, 528, 37		14, 528, 379	200 00
201. 00 Less Observation Beds	14, 520, 3/9	١	14, 520, 37			201.00
201.00 Less observation Beds 202.00 Total (see instructions)	14, 528, 379	0	14, 528, 37	9 0		
202. 00   TOTAL (SEE THISTI UCTIONS)	14, 320, 3/9	ı	14, 026, 3/	اح اح	14, 020, 3/9	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3042 Peri od: Worksheet C From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 965, 635 8, 965, 635 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 259, 871 259, 871 0.311936 0.000000 54.00 57.00 05700 CT SCAN 0.311876 0.000000 57.00 17, 414 0 17, 414 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0.000000 58.00 60.00 06000 LABORATORY 848, 263 Ω 848, 263 0.230364 0.000000 60.00 06500 RESPIRATORY THERAPY 0.456197 693, 661 693, 661 0.000000 65.00 65.00 C 06600 PHYSI CAL THERAPY 2, 308, 575 760, 045 3, 068, 620 0.000000 66.00 0.515526 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 176, 765 344, 175 2, 520, 940 0.525374 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 713, 565 72, 750 786, 315 0. 486294 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 303, 488 1.028186 0.000000 71.00 C 303, 488 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 310, 102 C 2, 310, 102 0. 295229 0.000000 73.00 74.00 07400 RENAL DIALYSIS 232, 800 232, 800 0.817835 0.000000 74.00 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 121, 756 121, 756 0.721353 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0.000000 0.000000 91.00 04951 OUTPATIENT THERAPY 0 0 0 0.000000 0.000000 91.01 91.01 04950 OUTPATIENT WOUND CENTER 0 0 0.000000 0.000000 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 117.00 200.00 Subtotal (see instructions) 18, 951, 895 1, 176, 970 20, 128, 865 200. 00 201.00 Less Observation Beds 201.00 18, 951, 895 202.00 Total (see instructions) 1, 176, 970 20, 128, 865 202.00

			10 12/31/2021	5/16/2022 12: 32 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
44. 00 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 311936			54.00
57. 00   05700   CT   SCAN	0. 311876			57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
60. 00  06000   LABORATORY	0. 230364			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 456197			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 515526			66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0. 525374			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 486294			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 028186			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 295229			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 817835			74.00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 721353			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 O4950 OUTPATIENT WOUND CENTER	0. 000000			93. 00
OTHER REIMBURSABLE COST CENTERS	T			
95. 00   09500   AMBULANCE   SERVI CES	0. 000000			95. 00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				447.00
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

Cost Center Description  Total Cost (from Wkst. B, Part I, coll. 26)  Title XIX Hospital PPS  Costs  Total Cost Adj.  Total Cost Disallowance	red:
Cost Center Description  Total Cost (from Wkst. B, Part I, col.)  Total Costs   Therapy Limit   Total Costs   RCE   Disallowance   Disallowan	
(from Wkst. B, Adj. Disallowance Part I, col.	
Part I, col.	
·	
26)	
1.00 2.00 3.00 4.00 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
	0. 00
	4. 00
ANCILLARY SERVICE COST CENTERS	
	4. 00
	7. 00
	8. 00
	0. 00
	5. 00
	6. 00
	7. 00
	8. 00
	1. 00
73.00   07300   DRUGS CHARGED TO PATIENTS   682,010   682,010   0 682,010   73.00   682,010   73.00   682,010   73.00   682,010   73.00   682,010   73.00   73	3.00
74. 00   07400   RENAL DI ALYSI S 190, 392 190, 392 0 190, 392 7	4. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 87,829 87,829 0 87,829 7	6. 00
OUTPATIENT SERVICE COST CENTERS	
91.00 09100 EMERGENCY 0 0 0 0 9	1. 00
	1. 01
93. 00   04950   OUTPATI ENT WOUND CENTER   O   O   O   S	3. 00
OTHER REI MBURSABLE COST CENTERS	
95. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0	5. 00
101.00 10100 HOME HEALTH AGENCY 0  0  0 10	1. 00
SPECIAL PURPOSE COST CENTERS	
	7. 00
200.00   Subtotal (see instructions)   14,528,379   0   14,528,379   0   14,528,379   0	
	1. 00
202. 00   Total (see instructions)   14, 528, 379  0  14, 528, 379  0  14, 528, 379 20	2. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3042 Peri od: Worksheet C From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 965, 635 8, 965, 635 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 259, 871 259, 871 0.311936 0.000000 54.00 57.00 05700 CT SCAN 0.311876 0.000000 57.00 17, 414 0 17, 414 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0.000000 58.00 60.00 06000 LABORATORY 848, 263 Ω 848, 263 0.230364 0.000000 60.00 06500 RESPIRATORY THERAPY 0.456197 693, 661 693, 661 0.000000 65.00 65.00 C 06600 PHYSI CAL THERAPY 2, 308, 575 760, 045 3, 068, 620 0.000000 66.00 0.515526 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 176, 765 344, 175 2, 520, 940 0.525374 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 713, 565 72, 750 786, 315 0. 486294 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 303, 488 1.028186 0.000000 71.00 C 303, 488 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 310, 102 C 2, 310, 102 0. 295229 0.000000 73.00 74.00 07400 RENAL DIALYSIS 232, 800 232, 800 0.817835 0.000000 74.00 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 121, 756 121, 756 0.721353 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0.000000 0.000000 91.00 04951 OUTPATIENT THERAPY 0 0 0 0.000000 0.000000 91.01 91.01 04950 OUTPATIENT WOUND CENTER 0 0 0.000000 0.000000 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 117.00 200.00 Subtotal (see instructions) 18, 951, 895 1, 176, 970 20, 128, 865 200. 00 201.00 Less Observation Beds 201.00 18, 951, 895 202.00 Total (see instructions) 1, 176, 970 20, 128, 865 202.00

				To 12/31/2021	Date/lime Prepared:   5/16/2022 12:32 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	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. 311936			54. 00
57. 00	05700 CT SCAN	0. 311876			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
60.00	06000 LABORATORY	0. 230364			60. 00
65.00	06500 RESPI RATORY THERAPY	0. 456197			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 515526			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 525374			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 486294			68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 028186			71. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 295229			73. 00
74. 00	07400 RENAL DI ALYSI S	0. 817835			74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 721353			76. 00
	OUTPATIENT SERVICE COST CENTERS				
91. 00	09100 EMERGENCY	0. 000000			91. 00
	04951 OUTPATIENT THERAPY	0. 000000			91. 01
93. 00	04950 OUTPATIENT WOUND CENTER	0. 000000			93. 00
	OTHER REIMBURSABLE COST CENTERS	T			
	09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS	T			
	06950 OTHER SPECIAL PURPOSE COST CENTERS				117. 00
200.00					200. 00
201.00					201. 00
202.00	Total (see instructions)				202. 00

 
 Heal th Financial Systems
 Lafayette Regional
 Rehabilitation Hospit

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY
 Provider CCN: 15 | Peri od: | Worksheet C | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021

			'	0 12/31/2021	5/16/2022 12:	32 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	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					_	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	81, 063	1, 265			0	54. 00
57. 00   05700   CT   SCAN	5, 431	85	5, 346	0	0	57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
60. 00   06000   LABORATORY	195, 409	3, 410			0	60.00
65. 00 06500 RESPI RATORY THERAPY	316, 446	17, 200			0	65. 00
66. 00   06600   PHYSI CAL THERAPY	1, 581, 953	247, 331			0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 324, 437	149, 133			0	67. 00
68. 00 06800 SPEECH PATHOLOGY	382, 380	19, 380			0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	312, 042	32, 748	1		0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	682, 010	46, 288			0	73. 00
74. 00   07400   RENAL DI ALYSI S	190, 392	2, 355			0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	87, 829	1, 109	86, 720	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS				_		
91. 00 09100 EMERGENCY	0	0	(	0	0	91. 00
91. 01  04951 OUTPATI ENT THERAPY	0	0	(	0	0	91. 01
93. 00 O4950 OUTPATIENT WOUND CENTER	0	0	(	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES	0	0	(	0		95. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	(	) 0	0	101. 00
SPECIAL PURPOSE COST CENTERS			1			
117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0		117. 00
200.00 Subtotal (sum of lines 50 thru 199)	5, 159, 392	520, 304	4, 639, 088	3 0	-	200. 00
201.00 Less Observation Beds	0	0		0	-	201. 00
202.00   Total (line 200 minus line 201)	5, 159, 392	520, 304	4, 639, 088	3  0	0	202. 00

						5/16/2022 12:32 pm
				e XIX	Hospi tal	PPS
	Cost Center Description		Total Charges			
			(Worksheet C,			
		Operating Cost		Ratio (col.	6	
		Reduction	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	LARY SERVICE COST CENTERS					
	RADI OLOGY-DI AGNOSTI C	81, 063	259, 871	l .		54.00
57. 00 05700	CT SCAN	5, 431	17, 414	0. 31187	76	57. 00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	00	58. 00
	LABORATORY	195, 409	848, 263			60.00
65. 00 06500	RESPI RATORY THERAPY	316, 446	693, 661	0. 45619	97	65. 00
66.00 06600	PHYSI CAL THERAPY	1, 581, 953	3, 068, 620	0. 51552	26	66. 00
67.00 06700	OCCUPATIONAL THERAPY	1, 324, 437	2, 520, 940	0. 5253	74	67. 00
68. 00 06800	SPEECH PATHOLOGY	382, 380	786, 315	0. 48629	94	68. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	312, 042	303, 488	1. 02818	36	71. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	682, 010	2, 310, 102	0. 29522	29	73.00
74. 00 07400	RENAL DIALYSIS	190, 392	232, 800	0. 81783	35	74.00
76. 00 03950	OTHER ANCILLARY SERVICE COST CENTERS	87, 829	121, 756	0. 7213	53	76. 00
OUTPA	TIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	0	C	0.00000	00	91.00
91. 01 04951	OUTPATI ENT THERAPY	o	O	0.00000	00	91. 01
93.00 04950	OUTPATIENT WOUND CENTER	o	O	0.00000	00	93. 00
OTHER	REIMBURSABLE COST CENTERS				<del>.</del>	
95. 00 09500	AMBULANCE SERVICES	0	C	0. 00000	00	95. 00
101. 00 10100	HOME HEALTH AGENCY	o	0	0. 00000	00	101.00
SPECI	AL PURPOSE COST CENTERS	'		•		
117. 00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.00000	00	117. 00
200.00	Subtotal (sum of lines 50 thru 199)	5, 159, 392	11, 163, 230			200. 00
201. 00	Less Observation Beds	0				201. 00
202. 00	Total (line 200 minus line 201)	5, 159, 392	11, 163, 230			202. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	.,,	,	1	T .	

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552							2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Prov	vider CO		Peri od:	Worksheet D	
					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/16/2022 12:	
			Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Swi ng	Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adj us	tment	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, 649, 277		0	1, 649, 27	7 8, 734	188. 83	30.00
44.00 SKILLED NURSING FACILITY	0				0	0.00	44.00
200.00 Total (lines 30 through 199)	1, 649, 277			1, 649, 27	7 8, 734		200.00
Cost Center Description	I npati ent	Inpat	tient				
	Program days	Prog	gram				
		Capi ta	l Cost				
		(col . 5	x col.				
		6	)				
	6. 00	7.	00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	4, 922		929, 421				30. 00
44.00 SKILLED NURSING FACILITY	0		0				44.00
200.00 Total (lines 30 through 199)	4, 922		929, 421				200. 00

Heal th	Fi nanci al	Systems	Lafaye	tte Regional Re	ehabi I	itation H	łospi t	In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF	INPATIENT ANCILLARY	SERVICE CAPITA	AL COSTS	Р	rovi der (	CN: 15-3042	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/16/2022 12:	pared: 32 pm
						Ti tl	e XVIII	Hospi tal	PPS	
	Cost	Center Description		Capi tal	Tota	l Charges	Ratio of Cos	st Inpatient	Capital Costs	
				Related Cost	(from	n Wkst. C,	to Charges	Program	(column 3 x	
				(from Wkst. B,	Part	I, col.	(col. 1 + co	I. Charges	column 4)	
				Part II, col.		8)	2)			
				26)						
				1.00		2.00	3.00	4. 00	5. 00	
	ANCI LLARY	SERVICE COST CENTERS	;					<u>.</u>		
54.00	05400 RADI	OLOGY-DI AGNOSTI C		1, 265		259, 87	0. 0048	68 121, 677	592	54.00
57.00	05700 CT S	SCAN		85		17, 414	0.0048	81 6, 666	33	57.00
	105000	ETLA BEGGNANGE LAAGE	NO (NDI)	1	l					

Health Financial Systems La	afayette Regional Re	habilitation H	ospi t	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	ER PASS THROUGH COST	rs Provider Co	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/16/2022 12:	pared: 32 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	Ŭ	Adjustments		Education Cost	
	Adjustments		_			
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(	0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	O	0		0		44.00
200.00 Total (lines 30 through 199)	o	0	1 0	o	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	•			
	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	8, 734	0.00	4, 922	30.00
44.00 04400 SKILLED NURSING FACILITY	İ	0	1	0.00	0	44.00
200.00 Total (lines 30 through 199)		Ō	8, 734			200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
44.00 04400 SKILLED NURSING FACILITY	o					44. 00
200.00 Total (lines 30 through 199)	0					200. 00
						•

Health Financial Systems I	_afayette Regional Reh	nabilitation H	oilitation Hospit		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA THROUGH COSTS	NT ANCILLARY SERVICE OTHER PASS			Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prep 5/16/2022 12:3		
		Title	: XVIII	Hospi tal	PPS		
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments			

					07 107 2022 12.	02 piii
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00   05400 RADI OLOGY-DI AGNOSTI C	C	0	(	0	0	54. 00
57. 00   05700 CT SCAN	C	0	(	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0	(	0	0	58. 00
60. 00   06000   LABORATORY	C	0	(	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	C	0	(	0	0	65.00
66. 00   06600 PHYSI CAL THERAPY	C	0	(	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0	(	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	C	0	(	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	(	0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	(	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	C	0	· C	0	0	74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	C	0	·	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS				•		1
91. 00 09100 EMERGENCY	C	0	(	0	0	91. 00
91. 01   04951 OUTPATI ENT THERAPY	C	0	·	0	0	91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	C	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	l c	0	0	200.00
		1	1	1	1	

	Financial Systems Lafaye  I ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	tte Regional Re				u of Form CMS-	2552-10
	TUNMENT OF INPATTENT/OUTPATTENT ANCILLARY SER H COSTS	VICE UTHER PASS	Provider Co		Peri od: From 01/01/2021	Worksheet D Part IV	
THRUUG	H C0313				To 12/31/2021	Date/Time Pre	pared:
						5/16/2022 12:	32 pm
			Title	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		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 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		0 259, 871	0. 000000	
57.00	05700 CT SCAN	0	0		0 17, 414	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0. 000000	
60.00	06000 LABORATORY	0	0		0 848, 263	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 693, 661	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 3, 068, 620	0.000000	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 2, 520, 940	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 786, 315	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 303, 488	0.000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 310, 102	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 232, 800	0.000000	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 121, 756	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0		0 0	0.000000	91. 00
91.01	04951 OUTPATI ENT THERAPY	O	0		0 0	0.000000	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0.000000	93. 00
	OTHER REIMBURSABLE COST CENTERS				•		1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 11, 163, 230		200.00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10									
APPORT	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASTHROUGH COSTS			CN: 15-3042 F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:		
				XVIII	Hospi tal	PPS			
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9			
		7)	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00			
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	121, 677		0	0	54.00		
57. 00	05700 CT SCAN	0.000000	6, 666			0	57.00		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0, 000			0	58.00		
60.00	06000 LABORATORY	0. 000000	536, 743		0	0	60.00		
65. 00	06500 RESPIRATORY THERAPY	0. 000000	368, 214		Ö	٥١	65. 00		
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 329, 075	C	260	0	66. 00		
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 239, 040	C	0	0	67. 00		
68.00	06800 SPEECH PATHOLOGY	0. 000000	377, 005	C	0	0	68. 00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	185, 387	C	0	0	71. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 347, 163	C	0	0	73. 00		
74.00	07400 RENAL DIALYSIS	0. 000000	186, 900	C	0	0	74. 00		
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	1, 067	C	0	0	76. 00		
	OUTPATIENT SERVICE COST CENTERS								
91. 00	09100 EMERGENCY	0. 000000	0	C	0	0	/ 1. 00		
91. 01	04951 OUTPATI ENT THERAPY	0. 000000	0	C	0	0	91. 01		
93. 00	04950 OUTPATIENT WOUND CENTER	0. 000000	0		0	0	93. 00		
0= 0-	OTHER REIMBURSABLE COST CENTERS						05.05		
95.00	09500 AMBULANCE SERVICES		F (00 007		0.00		95. 00		
200.00	Total (lines 50 through 199)		5, 698, 937	[ C	260	0	200. 00		

cial Systems	Lafayette Regional Rehab	oilitation Hospit	In Lieu	of Form (	CMS-2552

Heal th	Fi nanci al	Systems Lafaye	tte Regional Re	habilitation H	lospi t	In Lieu of Form CMS-2552-10		
APPORT	TIONMENT OF	F MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/16/2022 12:	
				Ti tl e	e_XVIII	Hospi tal	PPS	
					Charges		Costs	
	Cost	t Center Description	Cost to Charge			Cost	PPS Services	
				Servi ces (see		Rei mbursed	(see inst.)	
			Worksheet C,	inst.)	Servi ces	Services Not		
			Part I, col. 9		Subject To	Subject To		
					Ded. & Coins (see inst.)	Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00	5. 00	
	ANCLLLARY	SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
54 00		I OLOGY-DI AGNOSTI C	0. 311936		ol	0 0	0	54.00
	05700 CT S		0. 311876			0	0	
	1 1	NETIC RESONANCE IMAGING (MRI)	0. 000000	l .		0	0	
	06000 LABO		0. 230364	l .		0	0	60.00
65.00	06500 RESE	PI RATORY THERAPY	0. 456197	l c		0 0	0	65. 00
66.00		SI CAL THERAPY	0. 515526	260		0 0	134	66. 00
67.00	06700 OCCL	JPATI ONAL THERAPY	0. 525374	. l		0 0	0	67. 00
68.00	06800 SPEE	ECH PATHOLOGY	0. 486294	(		0	0	68. 00
71.00	07100 MEDI	ICAL SUPPLIES CHARGED TO PATIENTS	1. 028186	l c		0	0	71. 00
73.00	07300 DRUG	GS CHARGED TO PATIENTS	0. 295229	l c		0	0	73. 00
74.00	07400 RENA	AL DIALYSIS	0. 817835	C		0 0	0	74. 00
76.00	03950 OTHE	ER ANCILLARY SERVICE COST CENTERS	0. 721353	C	)	0 0	0	76. 00
		T SERVICE COST CENTERS						
	09100 EMEF		0. 000000			0	0	
91. 01	1 1	PATI ENT THERAPY	0. 000000		)	0	0	91. 01
93. 00		PATIENT WOUND CENTER	0. 000000	(	)	0 0	0	93. 00
		MBURSABLE COST CENTERS		1		_1	Γ	
		JLANCE SERVICES	0. 000000	l .		0		95. 00
200.00		total (see instructions)		260	)	0	134	200. 00
201.00		s PBP Clinic Lab. Services-Program						201. 00
202. 00		y Charges Charges (line 200 - line 201)		260		0	124	202. 00
202.00	net inet	charges (Title 200 - Title 201)	I	1 200	<b>1</b> 1	<b>υ</b>	134	1202.00

				To 12/31/2021	Date/Time Pre 5/16/2022 12:	
	_	Title	XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						4
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54. 00
57. 00  05700   CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
60. 00   06000   LABORATORY	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 PATIENTS	0	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 CENTERS	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0				91. 00
91. 01   04951 OUTPATIENT 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)	o	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	O					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	o	0				202. 00
	•					

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-7						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part I	narod:
				10 12/31/2021	Date/Time Pre 5/16/2022 12:	pareu: 32 pm
		Ti tl	e XIX	Hospi tal	PPS	<u>  </u>
Cost Center Description	Capi tal	Swi ng 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, 649, 277	C	1, 649, 27	7 8, 734	188. 83	30. 00
44.00   SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	1, 649, 277		1, 649, 27	7 8, 734		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	78	14, 729	9			30. 00
44.00   SKILLED NURSING FACILITY	0	[ C	)			44. 00
200.00 Total (lines 30 through 199)	78	14, 729	9			200. 00

Health Financial Systems	Lafayette Regional R	Rehabilitation Hospit	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPITAL COSTS	Provider CCN: 15-3042	From 01/01/2021	Worksheet D Part II Date/Time Prepared:

					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/16/2022 12:	pared: 32 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 265				0	0 00
57. 00	05700 CT SCAN	85	17, 414	•		0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C	0. 00000		0	58. 00
60.00	06000 LABORATORY	3, 410		•		0	60.00
65. 00	06500 RESPI RATORY THERAPY	17, 200		1		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	247, 331				0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	149, 133				0	67. 00
68. 00	06800 SPEECH PATHOLOGY	19, 380	786, 315	0. 02464	7 0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32, 748	303, 488	0. 10790	5 0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	46, 288	2, 310, 102	0. 02003	7 0	0	73. 00
74.00	07400 RENAL DIALYSIS	2, 355	232, 800	0. 01011	6 0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	1, 109	121, 756	0. 00910	8 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	C	0.00000	0	0	91. 00
91. 01	04951 OUTPATI ENT THERAPY	0	C	0.00000	0	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0	C	0.00000	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	520, 304	11, 163, 230	)	0	0	200. 00

Health Financial Systems Lafaye	tte Regional Rel	nabilitation H	ospi t	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	S Provider CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/16/2022 12:	pared: 32 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	ol	0		0		44.00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	,-			
		minus col. 4)				
	4. 00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	8, 734	0.00	78	30. 00
44. 00 04400 SKILLED NURSING FACILITY	١	0	0,			1
200.00 Total (Lines 30 through 199)		0	8, 734			200. 00
Cost Center Description	Inpati ent		0, 73-	T .	70	200.00
oust deliter beserver on	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
	0					44. 00
200.00   Total (lines 30 through 199)	0					200. 00

Health Financial Systems	Lafayette Regional Reha	bilitation H	ospi t	In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der Co	CN: 15-3042	Peri od: From 01/01/2021	Worksheet D	
THROUGH COSTS					Date/Time Prep 5/16/2022 12:3	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		

						5/16/2022 12:	32 pm_
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0		0	0	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	0	0	(	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	· C	0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	· C	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	(	0	0	91. 00
91. 01	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						1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	) c	0	0	200. 00
		1	'	•	ii.	•	•

		tte Regional Re				u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PASS	S Provider Co		Period: From 01/01/2021 To 12/31/2021		epared:
			Ti +I	e XIX	Hospi tal	5/16/2022 12: PPS	32 pm
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	5651 5611161 56561 F11 611	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 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		0 259, 871	0. 000000	
57. 00	05700  CT SCAN	0	0		0 17, 414	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0. 000000	
60.00	06000 LABORATORY	0	0		0 848, 263	0. 000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 693, 661	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 3, 068, 620	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 520, 940	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 786, 315	0.000000	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 303, 488	0.000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 310, 102	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 232, 800	0.000000	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 121, 756	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0		0 0	0. 000000	91. 00
91. 01	04951 OUTPATI ENT THERAPY	0	0		0	0. 000000	
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0	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 11, 163, 230		200. 00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10							
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				eri od:	Worksheet D	2552-10
	GH COSTS	02 0111211 17100			rom 01/01/2021	Part IV	
	556.16			T	o 12/31/2021	Date/Time Pre	
			T' 11	VI V		5/16/2022 12:	32 pm
	0 1 0 1 5 11			e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost	Inpatient	Inpatient	Outpati ent	Outpati ent	
		to Charges	Program Charges	Program Pass-Through	Program Charges	Program Pass-Through	
		(col . 6 ÷ col .	charges	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	0	0	0	54. 00
57. 00	05700 CT SCAN	0. 000000	0	Ö	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0	i o	0	0	58. 00
60.00	06000 LABORATORY	0. 000000	0	l d	Ō	Ö	60.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	0	C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	l c	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	l c	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	l c	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0	C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0	C	0	0	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	C	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 000000	0	C	0	0	91.00
91. 01	04951 OUTPATIENT THERAPY	0. 000000	0	C	0	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0. 000000	0	C	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES		·				95. 00
200.00	Total (lines 50 through 199)		0	C	0	0	200. 00

Health Financial Systems Lafaye	tte Regional Re	habilitation H	ospi t	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/16/2022 12:	
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(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	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 311936			0	0	
57. 00  05700   CT SCAN	0. 311876			0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
60. 00   06000   LABORATORY	0. 230364	0		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 456197	0		0 0	0	65.00
66. 00   06600 PHYSI CAL THERAPY	0. 515526	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 525374	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 486294	0		0 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 028186	0		0 0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 295229	0		0 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 817835	0		0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 721353	0		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	1	<u> </u>	<u>'</u>	<u> </u>	<u> </u>	1
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
91. 01 04951 OUTPATIENT THERAPY	0. 000000	0		0 0	0	91. 01
93. 00 04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	l 0	93.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0. 000000	0		0		95.00
200.00 Subtotal (see instructions)		l o		0 0	l 0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202. 00

In Lieu of Form CMS-2552-10
Worksheet D
Part V
B1/2021 Date/Time Prepared:
5/16/2022 12: 32 pm Peri od: From 01/01/2021 To 12/31/2021

			Ti tl	e XIX	Hospi tal	PPS
		Cos				
(	Cost Center Description	Cost	Cost			
		Reimbursed	Rei mbursed			
		Servi ces	Servi ces Not			
		Subject To	Subject To			
			Ded. & Coins.			
		(see inst.)	(see inst.)			
		6. 00	7. 00			
	ARY SERVICE COST CENTERS	1				
	RADI OLOGY-DI AGNOSTI C	0	0			54.0
57. 00   05700   0		0	0			57. 0
	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58. 0
	LABORATORY	0	0			60. 0
	RESPI RATORY THERAPY	0	0			65. 0
	PHYSI CAL THERAPY	0	0			66. 0
	OCCUPATIONAL THERAPY	0	0			67. 0
	SPEECH PATHOLOGY	0	0			68. 0
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.0
73. 00   07300   [	DRUGS CHARGED TO PATLENTS	0	0			73. 0
74. 00   07400 F	RENAL DIALYSIS	0	0			74.0
	OTHER ANCILLARY SERVICE COST CENTERS	0	0			76. 0
	IENT SERVICE COST CENTERS					
91. 00   09100   E		0	0			91.0
91. 01  04951 0	OUTPATI ENT THERAPY	0	0			91.0
93.00 04950 0	OUTPATIENT WOUND CENTER	0	0			93. 0
OTHER I	REIMBURSABLE COST CENTERS					
95. 00   09500   A	AMBULANCE SERVICES	0				95. 0
200.00	Subtotal (see instructions)	0	0			200. 0
	Less PBP Clinic Lab. Services-Program	0				201. 0
	Only Charges					
202.00	Net Charges (line 200 - line 201)	0	0			202. 0

Health Financial Systems	Lafayette Regional Rehab	ilitation Hospit	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3042	Peri od: From 01/01/2021	Worksheet D-1	
				Date/Time Prep 5/16/2022 12:	
		Title XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description					
				1 00	

		Title XVIII	Hospi tal	5/16/2022 12: 3 PPS	32 pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.	ed and newborn days)	vate room days,	8, 734 8, 734 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		31 of the cost	8, 734 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	4, 922	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)		0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period			0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e) , ,	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	m (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	9, 368, 987 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	·		0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	•	, , ,	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	·		0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	. 3		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		9, 368, 987	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	l and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges)			0	29. 00
31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 9, 368, 987	36. 00 37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 072. 70	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			5, 279, 829	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 5, 279, 829	40. 00 41. 00
	· · · · · · · · · · · · · · · · · · ·				

Heal th	Financial Systems Lafayer	tte Regional Reh	abilitation H	Hospi t	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-3042	Peri od: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	Date/Time Pre	
			Ti tl e	e XVIII	Hospi tal	5/16/2022 12: PPS	32 piii
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatient Days	col. 1	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			43.00
44. 00	CORONARY CARE UNIT						44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					2, 593, 082	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instruction	ons)		7, 872, 911	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program input	atient routine s	ervices (fron	m Wkst. D, sur	n of Parts I and	929, 421	50.00
51. 00	) Pass through costs applicable to Program inpo	ationt ancillary	, sarvicas (fi	com Wkst D s	cum of Darte II	250, 525	51, 00
	and IV)						
52. 00 53. 00				1, 179, 946 6, 692, 965	1		
33.00	medical education costs (line 49 minus line !		ateu, non-pny	ysician anesti	letist, and	0, 092, 903	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	
57. 00	Difference between adjusted inpatient operation	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)	5	,		,	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, ເ	updated and co	ompounded by the	0. 00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	rost report line	lated by the r	market hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	1
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	f the target		
(2.00	amount (line 56), otherwise enter zero (see	instructions)					62. 00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the o	cost reportino	a period (See	0	65. 00
	instructions) (title XVIII only)			,			
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	65)(title XVII	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 d	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	•					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				)		70. 00
71. 00	Adjusted general inpatient routine service of	-			•		71. 00
72. 00	Program routine service cost (line 9 x line						72. 00
73.00	Medically necessary private room cost applications are recorded to the cost application and the cost applications are recorded to the cost application and the cost applica						73.00
74. 00 75. 00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•	,		Part II column		74. 00 75. 00
. 5. 55	26, line 45)						
76.00	Per diem capital-related costs (line 75 ÷ line	ne 2)					76. 00

Health Financial Systems Lafa	yette Regional F	Rehabilitation H	ospi t	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/16/2022 12:	pared: 32 pm_
		Titl∈	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 THROUGH	SH COST					
90.00 Capital -related cost	1, 649, 27	7 9, 368, 987	0. 17603	6 0	0	90.00
91.00 Nursing Program cost		0 9, 368, 987	0.00000	0 0	0	91.00
92.00 Allied health cost		0 9, 368, 987	0.00000	0	0	92. 00
93.00 All other Medical Education		0 9, 368, 987	0.00000	0 0	0	93. 00

Health Financial Systems	Lafayette Regional Re	ehabilitation Hospit	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3042	Peri od: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/16/2022 12:	pared: 32 pm_
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

Part   All   MODIGER COMPONENTS   1.00			Title XIX	Hospi tal	97 167 2022 12: PPS	32 piii
Inpatient days (including private room days and swing-bed days, excluding newborn)   8,734   1.00		Cost Center Description				
IMPATEENT DAYS		DART I ALL PROVIDED COMPONENTS			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
1.00   Inpart ent days (Including private room days, excluding swing-bed and newborn days)   3.00   Annot complete this line.   3.00   Annot complete this	1. 00		s. excludina newborn)		8. 734	1. 00
do not complete this line. 4. 05 Semi-private room alsys (xecluding swing-bed and observation bed days) 5.00 Total swing-bed MY type inpatient days (including private room days) through December 31 of the cost 7.00 Total swing-bed MY type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed MY type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed MY type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed MY type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed MY type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 7.70 newborn days) (see instructions) 7.00 Swing-bed SMY type inpatient days applicable to the Program (excluding private room days) 7.00 Swing-bed SMY type inpatient days applicable to the Program (excluding private room days) 7.00 Swing-bed SMY type inpatient days applicable to the Program (excluding private room days) 7.00 Swing-bed SMY type inpatient days applicable to the Program (excluding private room days) 7.00 Total inpatient days applicable to the Program (excluding private room days) 7.00 Swing-bed MY type inpatient days applicable to the Program (excluding private room days) 7.00 Swing-bed MY type inpatient days applicable to the Program (excluding avaite one days) 7.00 Swing-bed MY type inpatient days applicable to Swing-bed MY (including private room days) 7.00 Swing-bed MY type inpatient days applicable to Swing-bed MY (including private room days) 7.00 Total Invasory days (title V or XIX only) 7.00 Total Invasory days (title V or XIX only) 7.00 Total Invasory days (title V or XIX only) 7.00 Narroom (applicable to Swing-bed MY services applicable to services after December 31 of the cost 7.00 Total Invasory days (title V or XIX only) 7.00 Narroom (applicable to Swing-bed MY ser	2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		8, 734	2. 00
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reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  70.00 Total general inpatient routine service cost (see instructions)  80.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  80.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  80.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  80.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  80.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  80.00 Total swing-bed cost (see instructions)  80.00 Decencal inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  80.00 Private room charges (excluding swing-bed charges)  80.00 Semi-private room charges (excluding swing-bed charges)  80.00 Semi-private room charges (excluding swing-bed charges)  80.00 Average private room per diem charge (line 29 + line 3)  80.00 Average per diem private room per diem charge (line 29 + line 3)  80.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  80.00 Private room cost differential (line 3 x line 35)  80.00 Average per diem private room cost differential (line 3 x line 35)  80.00 Private room cost differential service cost per diem (see instructions)  80.00 Private room cost differential service cost per diem (see instructions)  80.00 Program general inpatient routine service cost (line 9 x line 38)  80.00 Program general inpatient routin	19. 00		s through December 31 of	the cost	0.00	19. 00
reporting period Total general inpatient routine service cost (see instructions)  22.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  27.00  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  Private room charges (excluding swing-bed charges)  O Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  O Semi-private room per diem charge (line 27 * line 28)  O Average private room per diem charge (line 30 * line 3)  O Average per diem private room charge (line 30 * line 3)  O Average per diem private room cost differential (line 3 x line 31)  O Average per diem private room cost differential (line 3 x line 35)  O Private room cost differential adjustment (line 3 x line 35)  O PROFINIAL ADDUSTMENT (line 3 x line 35)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general inpatient routine service cost (line 9 x line 38)  O Adjusted general in		reporting period				
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 3 x line 31)  35.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  27.00 PRIVATE ROOM DIFFERENTIAL ADDUSTMENT  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  41.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20. 00		s after December 31 of th	e cost	0.00	20. 00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Fivate room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 3 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 368, 987)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21 00		3)		9 368 987	21 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge (line 29 + line 3)  30.00 Average per diem private room charge (line 29 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 35)  30.00 Average per diem private room cost differential (line 37 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 38)				ng period (line		•
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 9, 368, 987 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Semi-private room per diem charge (line 27 + line 28) 0.000 Semi-private room per diem charge (line 30 + line 3) 0.00 Semi-private room cost differential (line 32 minus line 33) (see instructions) 0.00 32.00 Semi-private room cost differential (line 32 minus line 33) (see instructions) 0.00 34.00 Semi-private room cost differential (line 3 x line 35) 0 37.00 Semi-private room cost differential (line 3 x line 35) 0 37.00 Semi-private room cost differential dipus service cost net of swing-bed cost and private room cost differential (line 9, 368, 987 37.00 Program general inpatient routine service cost per diem (see instructions) 1,072,70 38.00 Program general inpatient routine service cost per diem (see instructions) 1,072,70 38.00 Medically necessary private room cost applicable to the		·			_	
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25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Private room cost differential adjustment (line 3 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  31.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  32.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  33.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  34.00 Value (line 34 x line 35)  35.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00	1	31 of the cost reportin	g period (line	0	24. 00
x line 20)  26. 00  Total swing-bed cost (see instructions)  27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  31. 00  General inpatient routine service cost/charge ratio (line 27 ± line 28)  32. 00  Average private room per diem charge (line 29 ± line 3)  33. 00  Average semi-private room per diem charge (line 30 ± line 4)  34. 00  Average per diem private room cost differential (line 34 x line 31)  35. 00  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Onumber of the private room cost differential (line 3 x line 35)  Average inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 368, 987)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00  Algusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)			•			
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem pr	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Agiusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40.00	26 00				0	26 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.01 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 368, 987)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost (line 9 x line 38)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  31.00 Average per diem private room cost applicable to the Program (line 14 x line 35)  32.00 Average per diem private room cost applicable to the Program (line 14 x line 35)  33.00 Average per diem private room cost applicable to the Program (line 14 x line 35)		, ,	(line 21 minus line 26)		_	
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 368, 987)  38.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 000 000 000 000 000 000 000 000			d and observation bed cha	irges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room per diem charge (line 30 ÷ line 4)  35.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  36.00 Private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 368, 987)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  88.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.0000000  31.00  0.000000  32.00  32.00  32.00  34.00  35.00  36.00  37.00  36.00  37.00  38.00  37.00  38.00  39.00  40.00						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 368, 987) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 3			- line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00  34.00  35.00  36.00  37.00  37.00  38.00  38.00  38.00  40.00		,				•
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 35.00 36.00 37.00	33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 36.00 37.0				i ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Assertion 9, 368, 987		,	ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,072.70 38.00 Program general inpatient routine service cost (line 9 x line 38)  83,671 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		1	and private room cost dif	ferential (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,072.70 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  83,671 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00				7, 555, 767	000
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,072.7038.0039.00Program general inpatient routine service cost (line 9 x line 38)83,67139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 83,671 39.00 40.00	20.00				1 070 70	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			
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Heal th	Financial Systems Lafayet	tte Regional Re	habilitation H	lospi t	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	pared:
			Titl	e XIX	Hospi tal	5/16/2022 12: PPS	32 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)					2, 22	42. 00
42.00	Intensive Care Type Inpatient Hospital Units			1			1 42 00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			0	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		83, 671	49. 00
EO 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	ationt routing	corvi cos (from	. Wkst D sum	of Dorts L and	14, 729	50.00
50. 00	III)	atrent routine	services (Iron	I WKSt. D, Sulli	or Parts r and	14, 729	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (fr	om Wkst. D, s	um of Parts II	0	51. 00
52. 00	Total Program excludable cost (sum of lines!					14, 729	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		elated, non-phy	/sician anestho	etist, and	68, 942	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00					0	1	
57. 00	Difference between adjusted inpatient operati	ing cost and ta	arget amount (I	ine 56 minus l	line 53)	0	57. 00
58. 00					0 0. 00	58. 00 59. 00	
59. 00	market basket	borting period	ending 1996, u	ipuateu anu coi	iipourided by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% or	the target		
62.00	Relief payment (see instructions)	matractions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doos	mbor 21 of the	cost reporti	ng poriod (Soo	0	64. 00
04.00	instructions)(title XVIII only)	ts through bece	siliber 31 of the	cost reportir	ig period (see	0	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only). For	0	66. 00
<i>(</i> 7 00	CAH (see instructions)	a acata thraugh	Dogombor 21 o	of the cost re	aanting nariad		47.00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31 d	or the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	December 31 of	the cost repor	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient ( PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili						70. 00
71. 00	Adjusted general inpatient routine service co	,	ine 70 ÷ line	2)			71. 00
72.00	Program routine service cost (line 9 x line 1)		o (lino 14 v li	no 3E)			72.00
73. 00 74. 00	Medically necessary private room cost applications and Program general inpatient routine services.						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•	,		art II, column		75.00
	26, line 45)		<b>,</b>				
76. 00	Per diem capital-related costs (line 75 ÷ lin						76.00
77. 00 78. 00	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi den record	ls)			78. 00 79. 00
80. 00							80.00

Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation [Inpatient routine service cost limitation (line 9 x line 81)

Reasonable inpatient routine service costs (see instructions)

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Program inpatient ancillary services (see instructions)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

81.00 82.00

83.00

84.00

85. 00

86.00

87.00 0. 00 88. 00 0 89. 00

81.00

82.00 83.00

84.00

85.00 86.00

Health Financial Systems Lafa	ayette Regional R	ehabilitation	Hospi t	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/16/2022 12:	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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 THROUGH	GH COST					
90.00 Capital-related cost	1, 649, 27	7 9, 368, 98	7 0. 17603	6 0	0	90.00
91.00 Nursing Program cost		9, 368, 98	7 0.00000	0	0	91.00
92.00 Allied health cost		9, 368, 98	7 0. 00000	0	0	92.00
93.00 All other Medical Education		9, 368, 98	7 0. 00000	0 0	0	93. 00

Heal th Fi	nancial Systems Lafayette Regional Rehabi	ilitation H	ospi t	In Lie	eu of Form CMS-2	2552-10
		Provi der Co		Peri od:	Worksheet D-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narodi
				10 12/31/2021	5/16/2022 12:	32 pm
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			4 00	0.00	2)	
LAIF	DATI ENT DOUTINE CEDVICE COST CENTEDS		1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS DOO ADULTS & PEDIATRICS		ı	F 0/2 220		30.00
	CILLARY SERVICE COST CENTERS			5, 062, 230		30.00
	400 RADI OLOGY-DI AGNOSTI C		0. 31193	121, 677	37, 955	54.00
	700 CT SCAN		0. 31187			
	BOO MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		2,0,7	58.00
	DOO LABORATORY		0. 23036			
65. 00 06!	500 RESPI RATORY THERAPY		0. 45619			
66. 00 066	600 PHYSI CAL THERAPY		0. 51552	1, 329, 075	685, 173	66. 00
67. 00 06 <sup>-</sup>	700 OCCUPATI ONAL THERAPY		0. 52537	1, 239, 040	650, 959	67. 00
68. 00 068	BOO SPEECH PATHOLOGY		0. 48629	377, 005	183, 335	68. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 02818	185, 387	190, 612	71. 00
	300 DRUGS CHARGED TO PATIENTS		0. 29522			
	400 RENAL DIALYSIS		0. 81783	•		
	950 OTHER ANCILLARY SERVICE COST CENTERS		0. 72135	1, 067	770	76. 00
	TPATIENT SERVICE COST CENTERS		1		1	
	100 EMERGENCY		0.00000		_	91.00
	951 OUTPATIENT THERAPY		0. 00000 0. 00000		_	91. 01
	950 OUTPATLENT WOUND CENTER HER REIMBURSABLE COST CENTERS		0.00000	0	0	93. 00
	500 AMBULANCE SERVICES		I			95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			5, 698, 937	2, 593, 082	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		3, 070, 737		201. 00
202.00	Net charges (line 200 minus line 201)	(11110 01)		5, 698, 937		202.00
202.00	1.10 C 3.1d. 955 (1.1.10 255 1.1.10 251)		ı	3,070,707	I	1202.00

Health Financial Systems Lafayette Regional Reha	bilitation H	lospi t	In Li€	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-3042	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	narod:
			10 12/31/2021	5/16/2022 12:	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
ANDATI ENT. DOUTING OFFICE OF COST OFFITEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					00.00
30. 00   03000   ADULTS & PEDI ATRI CS   ANCI LLARY SERVI CE COST CENTERS			0		30. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 31193	6 0	0	54.00
57. 00   05700   CT   SCAN		0. 31193		0	57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 00000		0	
60. 00   06000   LABORATORY		0. 23036		0	
65. 00 06500 RESPIRATORY THERAPY		0. 45619		0	
66. 00 06600 PHYSI CAL THERAPY		0. 51552		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 52537		0	
68. 00   06800   SPEECH PATHOLOGY		0. 48629		l o	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 02818		0	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29522	.9	0	73. 00
74. 00   07400   RENAL DI ALYSI S		0. 81783	55 0	0	74. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS		0. 72135	63 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0.00000		0	91. 00
91. 01  04951 OUTPATI ENT THERAPY		0.00000			
93. 00 04950 OUTPATIENT WOUND CENTER		0.00000	00 0	0	93. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			0	0	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		1	0	1	202. 00

Health Financial Systems	Lafayette Regional Rehabilitation Hospit	In Li∈	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3042	Peri od:	Worksheet E		

From 01/01/2021 To 12/31/2021 Part B Date/Time Prepared: 5/16/2022 12:32 pm Title XVIII Hospi tal PPS 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) 2.00 134 2.00 259 3.00 OPPS payments 3 00 4.00 Outlier payment (see instructions) Ω 4.00 4.01 Outlier reconciliation amount (see instructions) 0 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.00 Line 2 times line 5 Λ 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 Transitional corridor payment (see instructions) 8.00 8.00 9 00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 0 10.00 Organ acquisitions 0 10.00 Total cost (sum of lines 1 and 10) (see instructions) 11.00 11.00 0 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 0 12.00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 13.00 14.00 Total reasonable charges (sum of lines 12 and 13) 0 14.00 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.00 Total customary charges (see instructions) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Ω 20 00 instructions) 21 00 Lesser of cost or charges (see instructions) 0 21 00 Interns and residents (see instructions) 0 22.00 22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 259 24.00 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25, 00 0 25, 00 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 52 26.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 207 27.00 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 0 207 30 00 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 0 31.00 32.00 Subtotal (line 30 minus line 31) 207 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33 00 33 00 0 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 36, 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 36, 00 0 207 37.00 Subtotal (see instructions) 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 0 39.99 Subtotal (see instructions) 207 40.00 40.00 40.01 Sequestration adjustment (see instructions) 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 207 41.00 Interim payments 41.00 Interim payments-PARHM 41.01 41.01 42.00 Tentative settlement (for contractors use only) 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) 0 43.00 Balance due provider/program-PARHM (see instructions) 43.01 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, O 44.00 §115 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 90.00 0 Outlier reconciliation adjustment amount (see instructions) 91.00 91.00 0 0.00 92 00 92 00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 94.00 Total (sum of lines 91 and 93) 0 94.00 Health Financial Systems

Lafayette Regional Rehabilitation Hospit

In Lieu of Form CMS-2552-10

Provider CCN: 15-3042

Period:
From 01/01/2021
To 12/31/2021

Part I
Date/Time Prepared:
5/16/2022 12: 32 pm

Title XVIII

Inpatient Part A

Part B

mm/dd/vvvv Amount

mm/dd/vvvv Amount

		Title	XVIII	Hospi tal	PPS	
	<u> </u>	Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		8, 699, 932		207	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
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	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 699, 932		207	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR	I				г оо
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 01	TENTATIVE TO PROVIDER		0			5. 02
5. 02			0			5. 02
5.03	Provider to Program				0	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROGRAM		0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
J. 77	5. 50-5. 98)					J. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		128, 826		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 828, 758		207	7. 00
7.00	Total mode out of program Trability (See Thistractions)		0, 020, 730	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	'			. '	

Health Financial Systems	Lafayette Regional Rehabilitation Hospit		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-3042	To 12/31/2021	Worksheet E-3 Part III Date/Time Prepared: 5/16/2022 12:32 pm	

				5/16/2022 12:	32 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8, 411, 002	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0264	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			378, 495	3. 00
4. 00	Outlier Payments			175, 650	•
5. 00	Unweighted intern and resident FTE count in the most recent countries the countries of the	ost reporting period en	ding on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)		9		
5. 01	Cap increases for the unweighted intern and resident FTE coun	t for residents that were	e displaced by	0.00	5. 01
	program or hospital closure, that would not be counted withou				
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	· - · · · · · · · · · · · · · · · · · ·			
6.00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	1
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8. 00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)	,		23. 928767	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
12.00	Teaching Adjustment (see instructions)			0	12. 00
13. 00	Total PPS Payment (see instructions)			8, 965, 147	1
14. 00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	1
15. 00	Organ acquisition (DO NOT USE THIS LINE)			Ĭ	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	1
17. 00	Subtotal (see instructions)	r de trons)		8, 965, 147	•
18. 00	Primary payer payments			0, 703, 147	18. 00
19. 00	Subtotal (line 17 less line 18).			8, 965, 147	19. 00
20. 00	Deductibles			91, 856	1
21. 00	Subtotal (line 19 minus line 20)			8, 873, 291	1
22. 00	Coi nsurance			74, 200	1
23. 00	Subtotal (line 21 minus line 22)			8, 799, 091	1
24. 00	Allowable bad debts (exclude bad debts for professional servi-	cas) (saa instructions)		45, 641	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistructions)		29, 667	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		38, 525	1
27. 00	Subtotal (sum of lines 23 and 25)	ructions)		8, 828, 758	1
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ino 40)		0, 828, 738	28.00
29. 00	Other pass through costs (see instructions)	THE 49)		0	29. 00
30. 00				0	30.00
	Outlier payments reconciliation			0	1
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	2)		0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instruction	5)		-	31.50
31. 98	Recovery of accelerated depreciation.			0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration			0 000 750	31. 99
32. 00	Total amount payable to the provider (see instructions)			8, 828, 758	1
32. 01	Sequestration adjustment (see instructions)			0	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33. 00	Interim payments			8, 699, 932	ı
34.00	Tentative settlement (for contractor use only)	,,		0	
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0			128, 826	1
36. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	36. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			175, 650	1
51. 00	Outlier reconciliation adjustment amount (see instructions)			0	51. 00
52.00	The rate used to calculate the Time Value of Money			0. 00	1
53.00	Time Value of Money (see instructions)			0	53. 00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND				
99. 00	Teaching Adjustment Factor for the cost reporting period imme		ry 29, 2020.	0. 000000	•
99. 01	Calculated Teaching Adjustment Factor for the current year. (	see instructions)		0. 000000	99. 01

Health Financial Systems

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

Provi der CCN: 15-3042

Pour pose Fund	oni y)				10 12/01/2021	5/16/2022 12:	32 pm
Current Asserts			General Fund		Endowment Fund	Plant Fund	
1.00			1.00		3. 00	4. 00	
2.00   Responsive Fundaments							
1.00   2.00   2.00   0   0   0   0   0   0   0   0   0			207, 907		0		
A. Comparison		1 . 3	0	1			
0			3 430 463	1			
1.00	5. 00		0		o o		
Propaid expenses   231,229   0   0   8   8   8   8   0   0   0   0	6.00	Allowances for uncollectible notes and accounts receivable	-831, 596		0	0	6. 00
1	7.00				0		
10.00   Due From other Funds		' '			0		
11.00   Total current assets (sum of lines 1-10)   3,185,798   0   0   0   11.00     EXED SSCIES			8, 388	1	1		
			2 105 700				1
12.00   Land   Improvements	11.00		3, 103, 770	9	<u> </u>		11.00
13.00   Land improvements	12.00		0	) (	0	0	12. 00
15.00	13.00	Land improvements	0	) (	0		
1.6.00   Accumulated depreciation	14.00		0		0		
17.00   Leasehol d Improvements	15. 00			1	-		
Racomulated depreciation		•	-16, 758	1	-		
19.00   Fixed equipment		•	0	1	1		
Accumulated depreciation		•	21 880	1	1		
21.00   Automobiles and trucks	20. 00	1		1	o o	•	
23.00   Major movable equipment   2, 958, 833   0   0   0   23.00	21. 00	•		1	0	0	21. 00
24.00   Accumulated depreciation   -2,086,761   0   0   0   24.00	22. 00	•	1	1	0		
25.00   Minor equipment depreciable   0 0 0 0 0 0 25.00	23. 00	1 -		1	-		
Account ated depreciation   0   0   0   0   26.00		•	-2, 086, 761		0		
No.   According to the second secon			0				
28.00   Accumula Ted depreciation   0   0   0   28.00   0   0   0   0   0   29.00   0   0   0   0   0   0   0   0   0	27. 00	•					
Total fixed assets (sum of lines 12-29)   991,284   0   0   0   0   30.00	28. 00		0		o o		
OTHER ASSETS   Investments	29. 00	Mi nor equi pment-nondepreci abl e	0	) (	0	0	29. 00
Investments	30.00		991, 284	. (	0	0	30.00
0	21 00						21 00
0			0			-	
152,730,940   0   0   0   34,00   35.00   152,730,940   0   0   0   35.00   35.00   152,730,940   0   0   0   35.00   35.00   152,730,940   0   0   0   35.00   35.00   152,730,940   0   0   0   35.00   35.00   152,730,940   0   0   0   35.00   35.00   152,730,940   0   0   0   35.00   35.00   152,730,940   0   0   0   35.00   35.00   152,730,940   0   0   0   35.00   152,730,940   0   0   0   35.00   152,730,940   0   0   0   35.00   152,730,940   0   0   0   35.00   152,730,940   0   0   0   0   35.00   152,730,940   0   0   0   0   35.00   152,730,940   0   0   0   0   0   0   35.00   152,730,940   0   0   0   0   0   0   0   35.00   152,730,940   0   0   0   0   0   0   0   0   0		· ·		1	-		
Total other assets (sum of lines 31-34)   152, 730, 940   0   0   0   35.00	34. 00		152, 730, 940		o o	•	1
CURRENT LIABILITIES   Accounts payable   Accounts payable   377, 245   0   0   0   37. 00   38. 00   Salaries, wages, and fees payable   606, 670   0   0   0   38. 00   39. 00   Payroll taxes payable   65, 414   0   0   0   0   39. 00   0   0   0   0   0   0   0   0   0	35.00	Total other assets (sum of lines 31-34)			0	0	35. 00
Accounts payable   377, 245   0   0   0   0   33. 00	36. 00		156, 908, 022	! (	0	0	36. 00
Salaries, wages, and fees payable   606,670   0   0   0   38.00	07.00		077.045				1 07 00
Payrol   taxes payable   65,414   0   0   0   0   39,00     40.00   Notes and loans payable (short term)   0   0   0   0   0   0     41.00   Deferred income   0   0   0   0   0     42.00   Accelerated payments   0   0   0   0   0     43.00   Due to other funds   0   0   0   0   0   0     44.00   Other current liabilities (sum of lines 37 thru 44)   170,852,103   0   0   0   0     45.00   Interval   Int				1			
Notes and Loans payable (short term)				1	-		
11.00   Deferred income   0   0   0   0   0   0   0   0   0	40.00		00,111		o o		
43. 00   Due to other funds   0   0   0   0   0   0   44. 00	41.00		0		0	0	
169,802,774   0   0   0   0   0   0   0   0   0	42.00		0				42. 00
Total current liabilities (sum of lines 37 thru 44)   170, 852, 103   0   0   0   0   0   0   0   0   0	43.00		0	)	0		
LONG TERM LIABILITIES				•	-		
46. 00 Mortgage payable	45.00		170, 852, 103	i]	0		45.00
47.00   Notes payable   246,544   0 0 0   0   47.00   48.00   Unsecured Loans   0 0 0 0 0   49.00   Other Long term Liabilities (sum of Lines 46 thru 49)   1,249,417   0 0 0   51.00   Total Liabilities (sum of Lines 45 and 50)   172,101,520   0    CAPITAL ACCOUNTS   52.00   53.00   Specific purpose fund   53.00   54.00   Donor created - endowment fund balance - restricted   55.00   55.00   Donor created - endowment fund balance   55.00   56.00   Governing body created - endowment fund balance   56.00   57.00   Plant fund balance - invested in plant   0   58.00   Plant fund balance - reserve for plant improvement, replacement, and expansion   70.00   59.00   Total Liabilities and fund balances (sum of Lines 51 and   156,908,022   0   0   0   60.00    10   47.00   0   0   47.00   0   0   48.00   0   0   0   49.00   0   48.00   0   0   0   49.00   0   0   0   49.00   0   0   0   49.00   0   0   0   49.00   0   0   0   49.00   0   0   0   49.00   0   49.00   0   0   49.00	46 00		1 0		0	0	46 00
48.00 Unsecured Loans 0 0 0 0 0 48.00 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 1, 249, 417 0 0 0 0 50.00 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 156, 908, 022  0 0 0 0 0 48.00 0 0 0 49.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47. 00		246, 544		o o		
50. 00 Total long term liabilities (sum of lines 46 thru 49)	48.00		0	1	0		1
51. 00 Total liabilities (sum of lines 45 and 50)	49. 00		1, 002, 873	3	0		1
CAPITAL ACCOUNTS  52. 00 General fund balance 53. 00 Specific purpose fund 54. 00 Donor created - endowment fund balance - restricted 55. 00 Donor created - endowment fund balance - unrestricted 56. 00 Governing body created - endowment fund balance 66. 00 Plant fund balance - invested in plant 67. 00 Plant fund balance - reserve for plant improvement, replacement, and expansion 69. 00 Total fund balances (sum of lines 52 thru 58) 60. 00 Total liabilities and fund balances (sum of lines 51 and 156, 908, 022  60. 00 Total liabilities and fund balances (sum of lines 51 and 156, 908, 022  60. 00 Total liabilities and fund balances (sum of lines 51 and 156, 908, 022  60. 00 Total liabilities and fund balances (sum of lines 51 and 156, 908, 022  60. 00 Total liabilities and fund balances (sum of lines 51 and 156, 908, 022  60. 00 Total liabilities and fund balances (sum of lines 51 and 156, 908, 022	50.00	,					
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 53.00 54.00 55.00 56.00 56.00 57.00 58.00 59.00	51. 00		172, 101, 520	)  (	0	0	51.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 54.00 55.00 56.00 57.00 58.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00	52.00		-15, 193, 498				52. 00
55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 55.00 Total liabilities and fund balances (sum of lines 51 and 156,908,022 0 0 0 60.00							53. 00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 56.00 Total liabilities and fund balances (sum of lines 51 and 156,908,022 0 0 0 60.00					0		
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 156,908,022 0 57.00 0 57.00 0 58.00 0 0 0 59.00 0 0 60.00					0		1
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 156,908,022 0 0 0 60.00							
replacement, and expansion   59.00   Total fund balances (sum of lines 52 thru 58)   -15,193,498   0   0   0   59.00   60.00   Total liabilities and fund balances (sum of lines 51 and   156,908,022   0   0   0   60.00	58. 00	· ·		1			
60.00 Total liabilities and fund balances (sum of lines 51 and   156,908,022   0   0   0   60.00		repl acement, and expansion		[			
	59. 00				0		
[94]	60.00		156, 908, 022	2	0	0	60.00
		( <sup>לכ</sup> ין	I	I	1	I	I

<u>Lafayette Regional Rehabi</u>litation Hospit In Lieu of Form CMS-2552-10 Health Financial Systems STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-3042 Peri od: Worksheet G-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/16/2022 12:32 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period -16, 213, 995 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 1, 020, 497 2.00 3.00 Total (sum of line 1 and line 2) -15, 193, 498 0 3.00 4.00 0 Additions (credit adjustments) (specify) 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) -15, 193, 498 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -15, 193, 498 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00

0

0

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12. 00 13. 00

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16.00

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19.00

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9.00

10.00

11.00

12.00

13. 00 14. 00

15. 00 16. 00

17.00

18.00

19.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

 
 Heal th Financial
 Systems
 Lafayette
 Regional
 Rehabilitation
 Hospit

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15 Provider CCN: 15-3042

			0 12/31/2021	5/16/2022 12:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	· · · · · · · · · · · · · · · · · · ·	1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	8, 965, 63	5	8, 965, 635	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7. 00	SKILLED NURSING FACILITY			0	7. 00
8.00	NURSING FACILITY			_	8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	8, 965, 63	5	8, 965, 635	10.00
10.00	Intensive Care Type Inpatient Hospital Services	0, 700, 00	4	0, 700, 000	10.00
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00
10.00	11-15)	`   '	ή	U	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 965, 63		8, 965, 635	17. 00
18. 00	Ancillary services	9, 986, 260			18. 00
19. 00	Outpatient services		) 1, 176, 970	11, 163, 230	19. 00
20. 00	RURAL HEALTH CLINIC			0	20. 00
21. 00			-	0	21. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER   HOME HEALTH AGENCY	'		0	21.00
			0	0	
23. 00 24. 00	AMBULANCE SERVICES	· '	٥	U	23. 00 24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)	10.051.00	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3 to We	kst. 18, 951, 89	1, 176, 970	20, 128, 865	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		12 701 E//		20.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200)		13, 781, 566		29. 00
	ADD (SPECIFY)				30.00
31.00					31.00
32. 00					32. 00
33.00					33.00
34. 00					34.00
35. 00	T + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 +	'			35.00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39.00		1	1		39. 00
40.00					40.00
41.00	T	'			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	anster	13, 781, 566		43. 00
	to Wkst. G-3, line 4)				

Health Financial Systems Lafayette Regional Rehab		oilitation Hospit	In Lie	In Lieu of Form CMS-2552-10	
STATEMENT OF DEVENUES AND EVDENCES		Providor CCN: 15 2042	Pari ad:	Workshoot G_3	

Heal th	Financial Systems Lafayette Regional	Rehabilitation Hospit	In Lie	u of Form CMS-2	2552-10	
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-3042 Period:		Worksheet G-3			
	From 01/01/2021			Date/Time Pre		
				1. 00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		20, 128, 865	1. 00	
2.00	Less contractual allowances and discounts on patients' ac	counts		5, 776, 145	2.00	
3.00	Net patient revenues (line 1 minus line 2)			14, 352, 720	3.00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		13, 781, 566	4.00	
5.00	Net income from service to patients (line 3 minus line 4)			571, 154	5. 00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6. 00	
7. 00	Income from investments			453	7. 00	
8. 00	Revenues from telephone and other miscellaneous communica	tion services		0	8. 00	
9.00	Revenue from television and radio service			0	9. 00	
10. 00	Purchase di scounts			0	10. 00	
	Rebates and refunds of expenses			0	11. 00	
	Parking lot receipts			0	12.00	
	Revenue from Laundry and Linen service			0	13.00	
	Revenue from meals sold to employees and guests			7, 515		
	Revenue from rental of living quarters			0	15. 00	
	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16. 00	
	Revenue from sale of drugs to other than patients			0	17. 00	
	Revenue from sale of medical records and abstracts			241	18. 00	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00	
	Rental of vending machines			0	21. 00	
	Rental of hospital space			0	22. 00	
	Governmental appropriations			0	23. 00	
	MISC INC, TRANSPORT, EMP PHYS SVCS			21, 134		
	COVI D-19 PHE Fundi ng			420, 000		
	Total other income (sum of lines 6-24)			449, 343		
	Total (line 5 plus line 25)			1, 020, 497		
	OTHER EXPENSES (SPECIFY)			0	27. 00	
	Total other expenses (sum of line 27 and subscripts)	0)		0	28. 00	
29.00	Net income (or loss) for the period (line 26 minus line 2	8)		1, 020, 497	29.00	