This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-3042 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 4/30/2024 Time: 11:02 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Lafayette Regional Rehabilitation Hospital (15-3042) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Caleb Reed		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	Cal eb Reed			2
3	Signatory Title	EVP FINANCE			3
4	Date	(Dated when report is electronica			4

	·		Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	156, 323	0	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	TOTAL	0	156, 323		0		200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 4/30/2024 11:02 am 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 Hospi tal Lafayette Regional 153042 29200 5 04/18/2013 Ν 3.00 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) 01/01/2023 12/31/2023 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 UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N 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 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 3 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.

lealth Financial Systems	Lafayette Regional Rehab	ilitation Hospit	In Lie	u of Form CMS-2552-10

He HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Worksheet S-2 Provider CCN: 15-3042 Peri od: From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 4/30/2024 11:02 am In-State Medi cai d In-State Out-of Out-of 0ther Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap n in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 42 118 0 0 1, 346 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1. 00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Beginning: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39. 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) V XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 | Is this facility eligible for additional payment exception for extraordinary circumstances Ν N Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For Ν 56.00 cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

Health Financial Systems Lafayette Regi HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		abilitation H		In Lie Period:	u of Form CMS-2 Worksheet S-2	
TOSPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	HIA	Provider C	F	From 01/01/2023 To 12/31/2023	Part I	
				V	XVIII XIX	02 am
				1. 00	2.00 3.00	
9.00 Are costs claimed on line 100 of Worksheet A? If ye	s, compl	ete Wkst. D-2	, Pt. I. NAHE 413.85	Worksheet A	Pass-Through	59. 00
			Y/N	Li ne #	Qualification Criterion Code	
			1. 00	2.00	3.00	
20.00 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 cois "Y", are you impacted by CR 11642 (or subsequent adjustment? Enter "Y" for yes or "N" for no in colu	.85? (sellumn 1. CR) NAHE	ee If column 1	N			60.00
	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 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
51.01 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) 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
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
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
	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column				0.00	0.00	61. 20

3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		Enter in column 2, the program code. Enter in column		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00		3, the IME FTE unweighted count. Enter in column 4,		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00		the direct GME FTE unweighted count.		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00				
Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00			1.00	
your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00		ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00	62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which	0. 00	62.00
during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00		your hospital received HRSA PCRE funding (see instructions)		
Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00	62. 01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital	0.00	62. 01
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00		during in this cost reporting period of HRSA THC program. (see instructions)		
		Teaching Hospitals that Claim Residents in Nonprovider Settings		
"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter	N	63.00
		"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		

Heal th	Financial Systems	Lafayette Regio	onal Rehabi	ilitation Ho	ospi t	In Lie	eu of Form CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPI	<u> </u>		Provider CC	CN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I	pared:
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2.00	3.00	
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovi der	Settings				
64. 00	period that begins on or after J Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty trained n-primary o all nonpro d non-prima n column 3	residents care ovider ary care the ratio	O. C	0.00	0. 000000	64. 00
	(corumn r drvraed by (corumn	Program Name		am Code	Unweighted	Unwei ghted	Ratio (col. 3/	
		Ü			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
		1. 00	2	. 00	3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. 0			65. 00
					Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te	nospi tui	2//	
					1. 00	2.00	3.00	
	Section 5504 of the ACA Current		n Nonprovi	der Setting:	sEffective 1	or cost reporti	ng periods	
44 00	beginning on or after July 1, 20 Enter in column 1 the number of		., coro ro	si dont	0.0	0 00	0. 000000	44 00
66.00	FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider set ry care res 3 the ratio	ttings. sident o of	0.0	0. 00	0. 000000	66.00
		Program Name		am Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
67.00	Enter in column 1, the program	1. 00	2	. 00	3.00	4. 00 0 0. 00	5. 00 0. 000000	67.00
57. 00	and 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)				0.0	. O. O.	9. 300000	

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96.00

97.00

Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the

If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

applicable column.

applicable column.

94.00

95.00

96.00

Health Financial Systems Lafayette Regional Reha	bilitation H	lospi t	In Lie	u of Form CMS-	2552-
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-3042	Peri od:	Worksheet S-2	2
			From 01/01/2023 To 12/31/2023		
			10 12/31/2023	4/30/2024 11:	
	•	'	V	XI X	
			1. 00	2.00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the intestepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" focolumn 1 for title V, and in column 2 for title XIX.	erns and res yes or "N"	sidents post for no in	Y	Y	98. 0
Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX.	J	J	Y	Y	98.
Descritle V or XIX follow Medicare (title XVIII) for the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or	Y	Y	98.		
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a criticeimbursed 101% of inpatient services cost? Enter "Y" for yes			N 1	N	98.
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and				N	98.
in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98.
column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost r. Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.
Rural Providers					
05.00 Does this hospital qualify as a CAH?			N		105.
06.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive met	hod of paymen	t		106.
for outpatient services? (see instructions)					
07.00 Column 1: If line 105 is Y, is this facility eligible for cos training 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 y approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction)	1. (see ins ou train I&R and/or IRF	structions) Rs in an			107.
07.01 If this facility is a REH (line 3, column 4, is "12"), is it reimbursement for L&R training programs? Enter "Y" for yes or instructions)	eligible for				107.
08.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.
	Physi cal	Occupati ona		Respi ratory	
00 00 l 6 this hamital mustifies a CAU	1. 00	2.00	3. 00	4. 00	100
09.00 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.
				1.00	4
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work	' for yes or	"N" for no.	f yes,	N	110

110.00 Did this hospital participate in the Rural Community Hospital Demonstration Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, li applicable.	yes,	N	110. 00	
		1 00		
Att collective of the last collective of the col		1. 00	2.00	111 00
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co		N		111. 00
Health Integration Project (FCHIP) demonstration for this cost reporting p				
"Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e				
integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds;				
for telle-health services.	and/or C			
Tot tere-near til Services.				
	1. 00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model	N			112. 00
(PARHM) demonstration for any portion of the current cost reporting				
period? Enter "Y" for yes or "N" for no in column 1. If column 1 is				
"Y", enter 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				
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	N			0 115. 00
in column 1. If column 1 is yes, enter the method used (A, B, or E only)				
in column 2. If column 2 is "E", enter in column 3 either "93" percent				
for short term hospital or "98" percent for long term care (includes				
psychiatric, rehabilitation and long term hospitals providers) based on				
the definition in CMS Pub. 15-1, chapter 22, §2208.1.				1
116.00 Is this facility classified as a referral center? Enter "Y" for yes or	N			116. 00
"N" for no.				447.00

117. 00 118. 00

117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

	Lafayette Regional Reha				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provi der CC		eriod: rom 01/01/2023 o 12/31/2023	Worksheet S- Part I Date/Time Pi 4/30/2024 1	repared:
			Premi ums	Losses	Insurance	
			1.00	2.00	3. 00	_
118.01 List amounts of malpractice premiums a	nd paid losses:		1.00			0 118. 01
				4.00	0.00	
118.02 Are mal practice premiums and paid loss	es reported in a cost c	enter other t	han the	1. 00 N	2.00	118. 02
Administrative and General? If yes, s and amounts contained therein. 119.00 DO NOT USE THIS LINE						119. 00
120.00 s this a SCH or EACH that qualifies f §3121 and applicable amendments? (see "N" for no. Is this a rural hospital w Hold Harmless provision in ACA §3121 a Enter in column 2, "Y" for yes or "N"	instructions) Enter in with < 100 beds that quand applicable amendment	column 1, "Y" lifies for th	for yes or ne Outpatient	N	N	120. 00
121.00 Did this facility incur and report cos	ts for high cost implan	table devices	s charged to	N		121. 00
patients? Enter "Y" for yes or "N" for 122.00 Does the cost report contain healthcar		ned in §1903((w)(3) of the	N		122. 00
Act?Enter "Y" for yes or "N" for no in the Worksheet A line number where thes		is "Y", enter	in column 2			
123.00 Did the facility and/or its subprovide	rs (if applicable) purc			N		123. 00
services, e.g., legal, accounting, tax management/consulting services, from a						
for yes or "N" for no.	G					
If column 1 is "Y", were the majority professional services expenses, for se						
located in a CBSA outside of the main						
"N" for no. Certified Transplant Center Information	on					
125.00 Does this facility operate a Medicare-			Y" for yes	N		125. 00
and "N" for no. If yes, enter certific 126.00 If this is a Medicare-certified kidney			fication date			126. 00
in column 1 and termination date, if a 127.00 of this is a Medicare-certified heart		or the cortif	Fication data			127. 00
in column 1 and termination date, if a		er the certifi	reation date			127.00
128.00 If this is a Medicare-certified liver in column 1 and termination date, if a		er the certif	ication date			128. 00
129.00 If this is a Medicare-certified lung t	ransplant program, ente	r the certifi	cation date			129. 00
in column 1 and termination date, if a 130.00 of this is a Medicare-certified pancre		enter the cer	rtification			130. 00
date in column 1 and termination date,	if applicable, in colu	mn 2.			-	
131.00 If this is a Medicare-certified intest date in column 1 and termination date,			certi fi cati on			131. 00
132.00 If this is a Medicare-certified islet	transplant program, ent		ication date			132. 00
in column 1 and termination date, if a 133.00 Removed and reserved	pplicable, in column 2.					133. 00
134.00 If this is a hospital-based organ prod		PO), enter th	ne OPO number			134. 00
in column 1 and termination date, if a AII Providers	ppiicable, in column 2.					
140.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" fare claimed, enter in column 2 the hom	for no in column 1. If y	es, and home	office costs	Y	HB1609	140. 00
1.00	2. 00			3.00	of the	
If this facility is part of a chain or home office and enter the home office				e and address	or the	
141. 00 Name: ERNEST HEALTH INC	Contractor's Name: NOVI	TAS SOLUTION	S Contractor	's Number: 0401	1	141. 00
142.00 Street: 1024 N GALLOWAY AVE 143.00 City: MESQUITE	PO Box: State: TX		Zi p Code:	7514	.9	142. 00 143. 00
144.00 Are provider based physicians' costs i	ncluded in Worksheet A?				1.00 N	144. 00
145.00 If costs for renal services are claims	d on Wkst. A. line 74	are the costs	for	1. 00 Y	2.00	145. 00
inpatient services only? Enter "Y" for	yes or "N" for no in c	olumn 1. If o	column 1 is	'		
no, does the dialysis facility include period? Enter "Y" for yes or "N" for		or this cost	reporting			
146.00 Has the cost allocation methodology ch	anged from the previous			N		146. 00
Enter "Y" for yes or "N" for no in col yes, enter the approval date (mm/dd/yy		-2, cnapter ²	iu, 94020) IT			
gen and gen are community	JJ, ==:=::::: =:			1	1	1

Health Financial Systems	Lafayette Regior	nal Reha	bilitation Ho	ospi t		In Lie	u of Form CMS	i-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DAT	Ā	Provi der CC			ri od: om 01/01/2023 12/31/2023	Worksheet S- Part I Date/Time Pr 4/30/2024 1	epared:
							1. 00	_
147.00 Was there a change in the statisti	cal hasis? Enter "Y"	' for ve	s or "N" for	no			N N	147. 00
148.00 Was there a change in the order of							N N	148. 00
149.00 Was there a change to the simplifi					for no).	N	149.00
			Part A	Part	В	Title V	Title XIX	
			1.00	2.00		3. 00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '			nt for Part A	and Part		ee 42 CFR §413	. 13)	
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156. 00
157. 00 Subprovi der - IRF			N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF			N	N.		N	N	158. 00 159. 00
160. 00 HOME HEALTH AGENCY			N N	N N		N N	N N	160.00
161. 00 CMHC			įΝ	I N		N N	N N	161. 00
TOT. COCUMIC				14			1.00	101.00
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that h	nas one	or more campu	ises in di	fferer	nt CBSAs?	N	165. 00
, , , , , , , , , , , , , , , , , , , ,	Name		County	State	Zip (Code CBSA	FTE/Campus	
	0		1. 00	2. 00	3. 0	00 4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. (00 166. 00
							1.00	
Health Information Technology (HI) incentive in the A	Ameri can	Recovery and	d Reinvest	ment	Act		
167.00 s this provider a meaningful user 168.00 of this provider is a CAH (line 10	05 is "Y") and is a m	neani ngf	ul user (line			enter the	N	167. 00 168. 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)					hardshi p		168. 01	
169.00 If this provider is a meaningful utransition factor. (see instruction	ıser (line 167 is "Y"), enter the	0. (00169.00
	-,					Begi nni ng	Endi ng	
						1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	eginning date and er	ndi ng da	te for the re	eporting				170. 00
					-	1. 00	2. 00	
171.00 If line 167 is "Y", does this province section 1876 Medicare cost plans refer to yes and "N" for no in column 1876 Medicare days in column 2.	reported on Wkst. S-3 umn 1. If column 1 is	3, Pt. I	, line 2, col	. 6? Ente		N		0 171. 00

Heal th	Financial Systems Lafayette Regional Re	ehabilitation H	ospi t	In Lie	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pro 4/30/2024 11:	epared:
	<u> </u>			Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OUESTLONN	IΔI RF	1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1. 00
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare F	Program2 If	1. 00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provice officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
	Trefationships: (see Thatfaetrons)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports	1.61 1.5 1.11	1		1	
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4. 00
5. 00	Are the cost report total expenses and total revenues differenthese on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differenthese differenthese total revenues differenthese differen		N			5. 00
	Those on the fired financial statements: If yes, submit rec	CONCLETE A LEFOIT.		Y/N	Legal Oper.	
				1. 00	2.00	
6.00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	- N		6. 00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	netructi one		N		7. 00
8. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ed during the			8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	he current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. 00
					1. 00	
_	Bad Debts				1.00	
12.00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	oolicy change o	luring this co	ost reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or coinsurainstructions.	ance amounts wa	nived? If yes,	see	N	14. 00
15 00	Bed Complement Did total beds available change from the prior cost reporti	ng period2 lf	vas soo inct	ructions	N	15. 00
13.00	pro total beds available change from the prior cost reporti	,	t A		t B	13.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	04/16/2024	N	I	16. 00
10.00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	'	047 107 2024	IV		10.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
19. 00	1	N		N		19. 00

	Financial Systems Lafayette Regional R				u of Form C		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3042	Peri od: From 01/01/2023 To 12/31/2023	Worksheet Part II Date/Time 4/30/2024	Prepared:	
		Descri	pti on	Y/N	Y/N	11.02 dill	
)	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20. 00	
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date		
		1.00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EDT CHILDDENS H	OSDI TAI S)		1. 00		
	Capital Related Cost	LIT CHIEDRENS H	OSIT TALS)				
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions				22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost		23. 00	
	Were new leases and/or amendments to existing leases enter If yes, see instructions	· ·				24. 00	
	Have there been new capitalized leases entered into during instructions.	·	.			25. 00	
	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	·	0 .			26. 00	
27. 00	Has the provider's capitalization policy changed during th copy. Interest Expense	e cost reportin	g period? It	r yes, submit		27. 00	
28. 00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		bt Service F	Reserve Fund)		29. 00	
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	s, see		30. 00	
31. 00	Has debt been recalled before scheduled maturity without i instructions. Purchased Services	ssuance of new	debt? If yes	s, see		31. 00	
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		d through co	ontractual		32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		g to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
	Were services furnished at the provider facility under an If yes, see instructions.	Ü		. ,		34.00	
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ts with the	provi der-based		35. 00	
				Y/N	Date		
	Hama Offica Costs			1.00	2. 00		
36. 00	Home Office Costs Were home office costs claimed on the cost report?					36.00	
	If line 36 is yes, has a home office cost statement been p	repared by the	home office	?		37.00	
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of					38. 00	
	the provider? If yes, enter in column 2 the fiscal year en	d of the home o	ffi ce.				
	If line 36 is yes, did the provider render services to oth see instructions.	·	,	5,		39. 00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00	
		1	00	2.0	<u> </u>		
	Cost Report Preparer Contact Information	1.		2.1			
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	
42. 00	respectively. Enter the employer/company name of the cost report preparer.	Ernest Health	Inc			42. 00	

Heal th	Financial Systems	Lafayette Regional	Rehal	bilitation H	Hospi t	In Lie	u of Form	CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTI ONNAI RE		Provider (CCN: 15-3042	riod: om 01/01/2023 12/31/2023		Pre	pared: 02 am
				2	00				
					. 00				
	Cost Report Preparer Contact Information	on							
41.00	Enter the first name, last name and th	e title/position	Re	imbursement	Manager				41.00
	held by the cost report preparer in co	lumns 1, 2, and 3,			Ü				
	respectively.								
42.00	Enter the employer/company name of the	cost report							42.00
	preparer.	•							
43.00	Enter the telephone number and email a	ddress of the cost	ı						43.00
	report preparer in columns 1 and 2, re								

| In Lieu of Form CMS-2552-10 | Period: Worksheet S-3 | From 01/01/2023 Part I | To 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am
 Heal th Financial
 Systems
 Lafayette
 Regional
 Rehabilitation
 Hospit

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15 Provider CCN: 15-3042

	,						4/30/2024 11: (02 am_
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
	DADT I OTATIOTICAL DATA	1. 00		2. 00	3. 00	4. 00	5. 00	
4 00	PART I - STATISTICAL DATA	20.00		40	44.400	0.00	0	1 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
4.00	HMO IRF Subprovider							4. 00
5.00	•						o	5. 00
	Hospital Adults & Peds. Swing Bed SNF						0	6. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			40	14, 600	0.00	0	7. 00
7.00	beds) (see instructions)			40	14, 600	0.00	U	7.00
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)			40	14, 600	0.00	0	14. 00
15. 00	CAH visits			40	14,000	0.00	0	15. 00
15. 10	REH hours and visits					0.00	0	15. 10
16. 00	SUBPROVI DER - I PF					0.00	O I	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44.00		0	0		0	19. 00
20. 00	NURSING FACILITY			Ŭ,	Ĭ		Ĭ	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
24. 00	HOSPI CE							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
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			40				27.00
28.00	Observation Bed Days						0	28.00
29.00	Ambul ance Trips							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			o	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	1	0	0		0	34.00

33.01

34.00

0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-3042

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

4/30/2024 11:02 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 4,701 42 9, 432 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) 622 1, 464 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 0 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 Ω 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 4, 701 7.00 42 9, 432 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 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 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 4, 701 100.46 14.00 42 9, 432 0.00 14.00 CAH visits 15.00 15.00 15.10 REH hours and visits 0 0 15. 10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 0.00 19.00 0 0 0 0.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 0 O 0.00 22 00 0 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) 0 24. 10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 0.00 26.25 Total (sum of lines 14-26) 100.46 27.00 0.00 27.00 28 00 Observation Bed Days Ω 0 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 0 30.00 Employee discount days - IRF 0 31.00 31.00 32.00 Labor & delivery days (see instructions) 0 0 32.00 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions) 33.00 33.00 LTCH non-covered days

33.01

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

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

				10	0 12/31/2023	Date/IIme Pre 4/30/2024 11:0	
		Full Time	<u> </u>	Di sch	arges	17 007 202 1 111	02 0
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	337	2	632	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)			33	96		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	I NTENSI VE 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	0.00		007			13.00
14.00	Total (see instructions)	0. 00	C	337	2	632	•
15. 00 15. 10	CAH visits						15. 00 15. 10
16. 00	REH hours and visits SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - I FF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	0. 00					19.00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0. 00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00		•			23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CWHC - CWHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

Lafayette Regional Rehabilitation Hospit RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-3042 Peri od: Worksheet A From 01/01/2023 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am 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) 4.00 1.00 2.00 3.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1, 923, 579 1, 923, 579 209, 931 2, 133, 510 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 192, 943 192, 943 53, 988 2.00 246, 931 00300 OTHER CAP REL COSTS 263, 919 263, 919 -263, 919 3.00 Ω 3 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 571, 919 958, 896 1, 530, 815 1, 530, 815 4.00 00500 ADMINISTRATIVE & GENERAL 0 5.00 1, 747, 652 1, 424, 219 3, 171, 871 3, 171, 871 5.00 00700 OPERATION OF PLANT 0 62, 119 435, 776 497.895 497, 895 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 50, 515 50, 515 50, 515 8.00 9.00 00900 HOUSEKEEPI NG 169,873 95, 328 265, 201 0 265, 201 9.00 01000 DI ETARY 326, 442 242, 324 568, 766 0 568, 766 10.00 10.00 13 00 01300 NURSING ADMINISTRATION 408.476 32, 251 440, 727 0 440, 727 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 54, 895 7, 082 61, 977 61, 977 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 409, 734 30.00 03000 ADULTS & PEDIATRICS 2, 649, 220 3, 409, 734 30.00 760, 514 0 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 45, 126 45, 126 0 45, 126 54.00 05700 CT SCAN 0 0 57.00 57 00 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 Ω 0 Λ 58.00 60.00 06000 LABORATORY 0 79, 880 79, 880 0 79,880 60.00 06500 RESPIRATORY THERAPY 65.00 102, 785 29, 551 132, 336 0 132, 336 65.00 06600 PHYSI CAL THERAPY 66.00 608, 183 107, 732 715, 915 51, 739 767, 654 66 00 67.00 06700 OCCUPATIONAL THERAPY 411, 927 168, 281 580, 208 139, 182 719, 390 67.00 68.00 06800 SPEECH PATHOLOGY 215, 029 19, 206 234, 235 53, 379 287, 614 68.00 128, 150 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 44, 490 172, 640 172, 640 71 00 O 73.00 07300 DRUGS CHARGED TO PATIENTS 91,610 284, 950 376, 560 0 376, 560 73.00 74.00 07400 RENAL DIALYSIS 179, 014 179, 014 0 179, 014 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.00 0 -85, 323 -85, 323 -85, 323 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 04951 OUTPATIENT THERAPY 225, 637 18, 663 244, 300 -244, 300 0 91.01 91.01 04950 OUTPATIENT WOUND CENTER 93.00 0 93.00 0 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 SUBTOTALS (SUM OF LINES 1 through 117) 7, 690, 257 7, 362, 576 15, 052, 833 15, 052, 833 118. 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 NONREI MBURSABLE COST CENTERS 0 0 194. 01 200.00 TOTAL (SUM OF LINES 118 through 199) 7, 690, 257 7, 362, 576 15, 052, 833 15, 052, 833 200. 00

Peri od: Worksheet A From 01/01/2023 Date/Time Prepared: 4/20/2024 11:02 am

				4/30/2024 11:	02 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	27, 630	2, 161, 140		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	13, 405	260, 336		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 456	1, 528, 359		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	705, 586	3, 877, 457		5. 00
7.00	00700 OPERATION OF PLANT	-11, 286	486, 609		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	50, 515		8. 00
9.00	00900 HOUSEKEEPI NG	0	265, 201		9. 00
10.00	01000 DI ETARY	-6, 929	561, 837		10.00
13.00	01300 NURSING ADMINISTRATION	0	440, 727		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-120	61, 857		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-168	3, 409, 566		30.00
44.00	04400 SKILLED NURSING FACILITY	o	0		44. 00
	ANCILLARY SERVICE COST CENTERS				1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	45, 126		54. 00
57.00	05700 CT SCAN	o	0		57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0		58. 00
60.00	06000 LABORATORY	o	79, 880		60.00
65.00	06500 RESPI RATORY THERAPY	o	132, 336		65.00
66.00	06600 PHYSI CAL THERAPY	o	767, 654		66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	719, 390		67. 00
68.00	06800 SPEECH PATHOLOGY	o	287, 614		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-6	172, 634		71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	376, 560		73. 00
74.00	07400 RENAL DIALYSIS	o	179, 014		74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	103, 800	18, 477		76. 00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0		91. 00
91. 01	04951 OUTPATI ENT THERAPY	o	0		91. 01
	04950 OUTPATIENT WOUND CENTER	o	0		93.00
	OTHER REIMBURSABLE COST CENTERS				1
95.00	09500 AMBULANCE SERVICES	0	0		95. 00
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>			
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		117. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	829, 456	15, 882, 289		118.00
	NONREI MBURSABLE COST CENTERS	<u> </u>			
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
	07950 MARKETI NG	0	0		194.00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 01
200.00		829, 456	15, 882, 289		200.00
				•	

Health Financial Systems

Lafayette Regional Rehabilitation Hospit

In Lieu of Form CMS-2552-10

Provider CCN: 15-3042

Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					4/30/2024 11:	
		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	42, 304	3, 793		1. 00
2.00	SPEECH PATHOLOGY	6800	1 <u>6, 2</u> 24			2. 00
	TOTALS		58, 528	5, 248		
	B - RCLS O/P THERAPY					
1.00	PHYSI CAL THERAPY	66.00	106, 690	8, 825		1. 00
2.00	OCCUPATI ONAL THERAPY	67.00	85, 974	7, 111		2. 00
3.00	SPEECH PATHOLOGY	68.00	32, 973	2, 727		3. 00
	TOTALS		225, 637	18, 663		
500.00	Grand Total: Increases		284, 165	23, 911		500.00

Health Financial Systems

Lafayette Regional Rehabilitation Hospit

In Lieu of Form CMS-2552-10

Provider CCN: 15-3042

Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					1	10 12/31/2023 Date/IIme F 4/30/2024 1	repared: 1:02 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	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, 528	5, 248	0		1. 00
2.00		0.00	0	0	0		2. 00
	TOTALS		58, 528	5, 248			
	B - RCLS O/P THERAPY						
1.00	OUTPATIENT THERAPY	91. 01	225, 637	18, 663	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
	TOTALS		225, 637	18, 663			
500.00	Grand Total: Decreases		284, 165	23, 911			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-3042 Worksheet A-7 Peri od: From 01/01/2023 To 12/31/2023 Part I Date/Time Prepared: 4/30/2024 11:02 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements 5.00 Bal ances 1.00 2.00 3.00 4. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 2.00 Land Improvements 2.00 0 0 0 0 Buildings and Fixtures Building Improvements 3.00 10, 661, 867 41, 400 0 3.00 41, 400 4.00 0 4.00 0 5.00 Fi xed Equipment 22, 926 1, 186 1, 186 0 5.00 6. 00 7. 00 Movable Equipment 0 -317, 910 0 3, 076, 662 -317, 910 6.00 0 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 13, 761, 455 -275, 324 -275, 324 0 8.00 0 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 10.00 10.00 13, 761, 455 -275, 324 0 -275, 324 0 Endi ng Bal ance Fully Depreciated

			ASSELS	
		6. 00	7. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES		
1.00	Land	0	0	1. 00
2.00	Land Improvements	0	0	2. 00
3.00	Buildings and Fixtures	10, 703, 267	0	3. 00
4.00	Building Improvements	0	0	4. 00
5.00	Fi xed Equi pment	24, 112	0	5. 00
6.00	Movable Equipment	2, 758, 752	0	6. 00
7.00	HIT designated Assets	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	13, 486, 131	0	8. 00
9.00	Reconciling Items	0	0	9. 00
10. 00	Total (line 8 minus line 9)	13, 486, 131	0	10.00

			1	0 12/31/2023	Date/IIme Pre 4/30/2024 11:0	
		SU	IMMARY OF CAPIT	AL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10.00	11.00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	166, 293	1, 718, 720	38, 566	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	131, 892	61, 051	0	0	0	2. 00
3.00 Total (sum of lines 1-2)	298, 185	1, 779, 771	38, 566	0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	<u> </u>				
1.00 CAP REL COSTS-BLDG & FLXT	0	1, 923, 579				1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	192, 943				2. 00
3.00 Total (sum of lines 1-2)	0	2, 116, 522				3. 00

Heal th F	Financial Systems Lafaye	tte Regional Re	<u>ehabilitation H</u>	lospi t	In Lie	u of Form CMS-2	2552-10
RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				F	rom 01/01/2023		
				7	Γo 12/31/2023	Date/Time Pre	
						4/30/2024 11:	02 am
		COMI	PUTATION OF RA	TIOS	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	
P	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	10, 727, 379	C	10, 727, 379	0. 795438	25, 376	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 758, 752	[c	2, 758, 752	0. 204562	6, 526	2. 00
3.00	Total (sum of lines 1-2)	13, 486, 131	C	13, 486, 13 ⁻	1. 000000	31, 902	3. 00

				(col. 1 - col.			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	10, 727, 379	0	10, 727, 379	0. 795438	25, 376	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 758, 752	0	2, 758, 752	0. 204562	6, 526	2.00
3.00	Total (sum of lines 1-2)	13, 486, 131	0	13, 486, 131	1. 000000	31, 902	3.00
		ALLOCA ⁻	TION OF OTHER C	CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	184, 555	0	209, 931	193, 923	1, 718, 720	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47, 462	0	53, 988	145, 297	61, 051	2.00
3.00	Total (sum of lines 1-2)	232, 017	0	263, 919	339, 220	1, 779, 771	3.00
			SU	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14. 00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	38, 566	25, 376	184, 555	0	2, 161, 140	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6, 526	47, 462	0	260, 336	2.00
3.00	Total (sum of lines 1-2)	38, 566	31, 902	232, 017	0	2, 421, 476	3.00
			· ·				

Health Financial Systems
ADJUSTMENTS TO EXPENSES Lafayette Regional Rehabilitation Hospit
Provider CCN: 15-3042

					To 12/31/2023		
				Expense Classification of		4/30/2024 11:0	02 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)		0				4 00
4.00	Trade, quantity, and time discounts (chapter 8)		U		0.00		4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	О	6. 00
7. 00	Tel ephone servi ces (pay	А	-1, 764	ADMINISTRATIVE & GENERAL	5. 00	О	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service	A	-9, 550	OPERATION OF PLANT	7. 00	О	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	0			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	О	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 189, 488			О	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		-6, 690	DI ETARY	10.00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17.00	pati ents		0		0.00		17.00
17.00	Sale of drugs to other than patients		U		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-120	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	l	
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25 00	limitation (chapter 14)		0	*** Cost Center Deleted ***	114 00		25 00
25.00	Utilization review - physicians' compensation		0	Cost center bereted	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
	COSTS-BLDG & FIXT Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP			27. 00
	COSTS-MVBLE EQUIP				2. 00		
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	INTEREST INCOME	В	1, 767	ADMINISTRATIVE & GENERAL	5.00	0	33. 00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-3042 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33. 02 MLSC I NCOME -16, 535 ADMI NI STRATI VE & GENERAL 33. 02 В 5.00 409 ADMINISTRATIVE & GENERAL 33.07 OTHER Α 5.00 33.07 EXPENSE-ADVERTI SI NG/MARKETI NG-33.08 Α -32, 785 ADMI NI STRATI VE & GENERAL 5.00 33.08 EXPENSE-ADVERTI SI NG/MARKETI NG-33.09 -2, 930 ADMI NI STRATI VE & GENERAL 33.09 5.00 **OTHER** Α EXPENSE-ADVERTI SI NG/MARKETI NG-33.14 BAD DEBT EXPENSE-BAD DEBT--Α -308, 392 ADMINISTRATIVE & GENERAL 5.00 33.14 OTHER EXPENSE-CONTRIBUTIONS / -1, 200 ADMI NI STRATI VE & GENERAL 33. 22 5.00 33. 22 SPONSO OTHER EXPENSE-CONTRIBUTIONS / 33.34 -5, 092 ADMI NI STRATI VE & GENERAL 5.00 33.34 Α SPONSO. OTHER EXPENSE-FLOWERS & -104 ADMINISTRATIVE & GENERAL 33.35 Α 5.00 33.35 GIFTS-33. 56 TAXES-FRANCHI SE FEES/BUSI NESS -372 ADMINISTRATIVE & GENERAL 5.00 33.56 Α TAX-33.69 OTHER EXPENSE-GIVEAWAYS---168 ADULTS & PEDIATRICS 30.00 33.69 Α -1, 854 ADMINI STRATI VE & GENERAL OTHER EXPENSE-GLVFAWAYS--33.74 Α 5.00 0 33.74 33.93 OTHER EXPENSE-GIVEAWAYS---561 ADMINISTRATIVE & GENERAL 5.00 33.93 Α 33. 95 OTHER FEES-LATE FEES-Α -6 MEDICAL SUPPLIES CHARGED TO 71.00 33.95 PATI ENTS 34 10 OTHER FEES-LATE FEES---1.736 OPERATION OF PLANT 7 00 34 10 Α O 34.13 OTHER FEES-LATE FEES--Α -239 DI ETARY 10.00 34.13 OTHER FEES-LATE FEES---150 ADMINISTRATIVE & GENERAL 5.00 34. 14 OTHER FEES-LATE FEES---75 ADMINISTRATIVE & GENERAL 5.00 34.18 34.18 Α -919 ADMINISTRATIVE & GENERAL TAXES-SALES TAX--34 21 34 21 Α 5 00 34.46 TAXES-USE TAX--Α -2, 666 ADMI NI STRATI VE & GENERAL 5.00 0 34.46 NON-OPERATING REALIZED 18, 982 ADMINISTRATIVE & GENERAL 34.47 Α 5.00 34.47 GAI N/LOSS-NON -7, 774 ADMI NI STRATI VE & GENERAL 34.51 34.51 MARKETING EXPENSE Α 5.00 0 34.52 MARKETING BENEFITS Α -868 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 34.52 TELEPHONE OPERATOR EXPENSE -12, 805 ADMINI STRATI VE & GENERAL 34.53 34.53 5.00 34. 54 TELEPHONE BENEFIT EXPENSE -1,588 EMPLOYEE BENEFITS DEPARTMENT 4.00 34.54 Α -537 CAP REL COSTS-MVBLE EQUIP 34.55 TELEVISION DEPRECIATION Α 2.00 34.55 34.56 UNALLOWABLE LOBBYING % OF -4, 277 ADMI NI STRATI VE & GENERAL 5.00 34.56 Α ASSOC DUES MED DIR 2022 OVER ACCRUAL AND 43, 455 ADMI NI STRATI VE & GENERAL 34.57 34.57 5.00 ACCRUA CONTRACT SERVICES-PHYSICIAN -106, 688 ADMINISTRATI VE & GENERAL 34.58 5.00 34.58 Α GUARANTE

103,800 OTHER ANCILLARY SERVICE COST

CENTERS

829, 456

76.00

34.59

50.00

Α

OUTSIDE LOA PRIOR PD INVOICES

TOTAL (sum of lines 1 thru 49)

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

34.59

50.00

& PRIO

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

From 01/01/2023

Dato/Time Propared

				0 12/31/2023	4/30/2024 11:	
	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 ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO Alloc - Cap Rel Bldg	27, 630	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	13, 942	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1, 467, 810	0	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	Intercompany Management Fees	0	319, 894	4.00
5. 00	0		0	1, 509, 382	319, 894	5. 00

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

			Related Organization(s) and	/or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
-9 (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 Re	ehabilitation Hospit	In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOW	E Provider CCN: 15-3042	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2023		
					To 12/31/2023	Date/Time Pre 4/30/2024 11:	
	N - ±	WI+ A 7 D-6			<u> </u>	4/30/2024 11:	UZ alli
		Wkst. A-7 Ref.	•				
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:					
1.00	27, 630	9	9				1.00
2.00	13, 942	9	9				2.00
3.00	1, 467, 810	0	ol				3.00
4.00	-319, 894	0	ol				4.00
5. 00	1, 189, 488						5. 00
* The	amounts on line	es 1-4 (and sub	bscripts as appropriate) are t	ransferred in detail to Wo	rksheet A column	6 lines as	
			se cost and negative amounts d				whi ch
			Lumin 1 1/ 2 the		9		WITH CIT

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

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.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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.

| Period: | Worksheet B | From 01/01/2023 | Part | I | To | 13/21/2023 | Part | To | 13/21/2023

				To	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 4/30/2024 11:	
			CAPI TAL REL	_ATED_COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DEPARTMENT		
		col . 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT	2, 161, 140	2, 161, 140				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	260, 336		260, 336			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 528, 359	8, 694		1, 538, 100		4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 877, 457	144, 405		377, 626	4, 416, 883	5. 00
7.00	00700 OPERATION OF PLANT	486, 609	497, 018		13, 422	1, 056, 921	7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	50, 515 265, 201	0 14, 083	_	0 36, 705	50, 515 317, 685	8. 00 9. 00
9. 00 10. 00	01000 DI ETARY	561, 837	198, 336		70, 536	854, 601	10.00
13. 00	01300 NURSING ADMINISTRATION	440, 727	22, 686		88, 262	554, 408	13.00
16. 00	01600 MEDICAL RECORDS & LI BRARY	61, 857	23, 547		11, 861	100, 101	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	01,007	20,017	2,000	11,001	100, 101	10.00
30.00	03000 ADULTS & PEDIATRICS	3, 409, 566	881, 917	106, 239	572, 433	4, 970, 155	30. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	o	0	44.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	45, 126	0		0	45, 126	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	79, 880	0	0	0	79, 880	60.00
65. 00	06500 RESPI RATORY THERAPY	132, 336	9, 056		22, 209	164, 692	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	767, 654 719, 390	154, 412 86, 082		141, 820 116, 725	1, 082, 487 932, 567	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	287, 614	9, 962		57, 093	355, 869	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	172, 634	20, 830		9, 613	205, 586	1
73.00	07300 DRUGS CHARGED TO PATIENTS	376, 560	25, 358		19, 795	424, 768	1
74. 00	07400 RENAL DIALYSIS	179, 014	0		0	179, 014	74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	18, 477	0	0	o	18, 477	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0	0	0	91. 00
91. 01	04951 OUTPATI ENT THERAPY	0	0		0	0	91. 01
93. 00	04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS		_				
	09500 AMBULANCE SERVICES	0	0		0	0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
117 00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	ol	0] 117. 00
117.00	1	15, 882, 289	2, 096, 386		1, 538, 100	15, 809, 735	
110.00	NONREI MBURSABLE COST CENTERS	15, 662, 269	2,090,300	252, 550	1, 556, 100	15, 607, 735] 110.00
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	64, 663	7, 789	ol	72, 452	192 00
	07950 MARKETI NG		91	11	o		194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS		0	0	Ō		194. 01
200.00		1					200. 00
201.00	Negative Cost Centers		0	0	o		201. 00
202.00	TOTAL (sum lines 118 through 201)	15, 882, 289	2, 161, 140	260, 336	1, 538, 100	15, 882, 289	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				''	0 12/31/2023	4/30/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	<u> </u>
		& 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, 416, 883					5. 00
7.00	00700 OPERATION OF PLANT	407, 164	1, 464, 085				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	19, 460	0	69, 975			8. 00
9.00	00900 HOUSEKEEPI NG	122, 384	13, 645	0	453, 714		9. 00
10.00	01000 DI ETARY	329, 223	192, 175	0	60, 115	1, 436, 114	10.00
13.00	01300 NURSING ADMINISTRATION	213, 578	21, 982	0	6, 876	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	38, 563	22, 815	0	7, 137	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	1, 914, 678	854, 521	69, 975	267, 304	1, 436, 114	30.00
44.00	l l	0	0	1	0	0	44.00
	ANCILLARY SERVICE COST CENTERS				-1		
54.00		17, 384	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	30, 773	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	63, 445	8, 775	0	2, 745	0	65. 00
66.00	06600 PHYSI CAL THERAPY	417, 013	149, 616	0	46, 802	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	359, 258		1	26, 091	0	67.00
68. 00	06800 SPEECH PATHOLOGY	137, 094	9, 653		3, 019	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	79, 199		1	6, 313	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	163, 636	24, 570	0	7, 686	0	73.00
74.00	07400 RENAL DIALYSIS	68, 963	0	i	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	7, 118	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS			•			1
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91. 01	04951 OUTPATIENT THERAPY	0	0	0	0	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
101.00	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS				•		
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117. 00
118.00		4, 388, 933	1, 401, 343	69, 975	434, 088	1, 436, 114	118. 00
	NONREI MBURSABLE COST CENTERS						1
192.00	19200 PHYSICIANS' PRIVATE OFFICES	27, 911	62, 654	0	19, 599	0	192. 00
194.00	0 07950 MARKETI NG	39	88	0	27	0	194. 00
194. 0°	1 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
200.00							200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 416, 883	1, 464, 085	69, 975	453, 714	1, 436, 114	202. 00
		•	•	•	•		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10

Provider CCN: 15-3042 Period: Worksheet B From 01/01/2023 Part I

					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 4/30/2024 11:	
	Cost Center Description	NURSI NG	MEDI CAL	Subtotal	Intern &	Total	
		ADMI NI STRATI ON	RECORDS &		Residents Cost		
			LI BRARY		& Post		
					Stepdown Adjustments		
		13.00	16. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS	10.00	10.00	21.00	20.00	20.00	
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						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	70/ 044					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	796, 844	1/0 /1/				13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	168, 616				16. 00
30. 00	03000 ADULTS & PEDIATRICS	796, 844	73, 226	10, 382, 81	7 0	10, 382, 817	30.00
44. 00		7 70, 044	73, 220			10, 302, 017	1
44.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0	,	9		141.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 489	63, 99	9 0	63, 999	54. 00
57. 00	05700 CT SCAN	o	0	·	ol ol	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0	(o o	0	58. 00
60.00	06000 LABORATORY	0	9, 963	120, 61	6 0	120, 616	60.00
65.00	06500 RESPIRATORY THERAPY	0	5, 787	245, 44	4 0	245, 444	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	24, 291	1, 720, 20	9 0	1, 720, 209	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	19, 574	1, 420, 89		1, 420, 898	1
68. 00	06800 SPEECH PATHOLOGY	0	7, 507	513, 14		513, 142	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 288			313, 569	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21, 505	·		642, 165	1
74. 00	07400 RENAL DIALYSIS	0	2, 986			250, 963	
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	J U	0	25, 59	5 0	25, 595	76. 00
91. 00	09100 EMERGENCY	l ol	0		ol ol	0	91. 00
91. 01	04951 OUTPATI ENT THERAPY		0			0	
93. 00	04950 OUTPATIENT WOUND CENTER	l ol	0		ol ol	0	1
	OTHER REIMBURSABLE COST CENTERS	,	-		-1		
95.00	09500 AMBULANCE SERVICES	0	0		0 0	0	95. 00
101.0	0 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0		117. 00
118. 0	, , , , , , , , , , , , , , , , , , , ,	796, 844	168, 616	15, 699, 41	7 0	15, 699, 417	118. 00
400.0	NONREI MBURSABLE COST CENTERS			100 //		100 (1)	
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0			182, 616	
	0 07950 MARKETI NG	0	0	25			194. 00 194. 01
200. 0	1 07951 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments		O		0 0	-	200. 00
200. 0	1 1		0		0 0		200.00
201.0	1 1 9	796, 844	168, 616	15, 882, 28	-	15, 882, 289	
202.0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7,70,044	100,010	10,002,20	71 YI	10, 002, 207	1202.00

Health Financial Systems

Lafayette Regional Rehabilitation Hospit

In Lieu of Form CMS-2552-10

Provider CCN: 15-3042

Period:
From 01/01/2023
To 12/31/2023

Part II
Date/Time Prepared:
4/30/2024 11: 02 am

CAPITAL RELATED COSTS

Cost Center Description

Directly
Assigned New

Directly
Assigned New

						4/30/2024 11:	02 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
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	0	8, 694	· ·	9, 741	9, 741	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	144, 405	· ·	161, 800	2, 391	5. 00
7.00	00700 OPERATION OF PLANT	0	497, 018	59, 872	556, 890	85	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	14, 083	1, 696	15, 779	232	9. 00
10.00	01000 DI ETARY	0	198, 336		222, 228	447	10.00
13.00	01300 NURSING ADMINISTRATION	0	22, 686	2, 733	25, 419	559	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	23, 547	2, 836	26, 383	75	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	881, 917	106, 239	988, 156	3, 627	30. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	o	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
57.00	05700 CT SCAN	O	0	0	o	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0	0	o	0	58. 00
60.00	06000 LABORATORY	o	0	0	o	0	60.00
65.00	06500 RESPIRATORY THERAPY	o	9, 056	1, 091	10, 147	141	65. 00
66.00	06600 PHYSI CAL THERAPY	o	154, 412		173, 013	898	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	86, 082		96, 452	739	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	9, 962		11, 162	361	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20, 830		23, 339	61	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	25, 358		28, 413	125	73. 00
74. 00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		ol	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	-			-1		
91.00	09100 EMERGENCY	0	0	0	0	0	91. 00
91. 01	04951 OUTPATIENT THERAPY	0	0	- 1	ol	0	91. 01
		0	0		ol	0	93. 00
	OTHER REIMBURSABLE COST CENTERS	-			-1		
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	0		ol		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	У	0	<u> </u>	<u> </u>		101.00
117 0	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	ol	0	117. 00
118.00		0	2, 096, 386		2, 348, 922		118. 00
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	2,070,300	232, 330	2, 340, 722	7, 741	1110.00
102 0	19200 PHYSI CI ANS' PRI VATE OFFI CES		64, 663	7, 789	72, 452	0	192. 00
	007950 MARKETING		91	11	102		194. 00
	107950 MARKETING 107951 OTHER NONREIMBURSABLE COST CENTERS		91		0		194. 00
200. 0		١	U	١	ol Ol	U	200. 00
	1 1		_		O O	0	ł
201. 00 202. 00		0	0 141 140	260, 336	2, 421, 476		201. 00 202. 00
202.00	TOTAL (Suil Titles TTO THEOUGH 201)	١	2, 161, 140	200, 330	2,421,470	7, /41	1202. UU

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: |

				''	0 12/31/2023	4/30/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	<u> </u>
		& 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	164, 191					5. 00
7. 00	00700 OPERATION OF PLANT	15, 136	572, 111				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	723	0	723			8.00
9. 00	00900 HOUSEKEEPING	4, 550	5, 332		25, 893		9. 00
10.00	01000 DI ETARY	12, 239	75, 095		3, 431	313, 440	
13. 00	01300 NURSI NG ADMI NI STRATI ON	7, 940			392	0 10, 110	
16. 00		1, 434	8, 915	1		0	16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 101	0, 713	1	107		10.00
30. 00	03000 ADULTS & PEDIATRICS	71, 172	333, 916	723	15, 255	313, 440	30.00
44. 00	l l	71,172	333, 710		· · ·	313, 440	44. 00
44.00	ANCILLARY SERVICE COST CENTERS		0	<u> </u>	U U	U	44.00
54. 00		646	0			0	54.00
57. 00	05700 CT SCAN	040	0		0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58.00
60.00	06000 LABORATORY	1 144	0		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	1, 144 2, 359	2 420		157	0	65.00
	06600 PHYSI CAL THERAPY	1	3, 429	1	· ·	0	
66. 00	1 1	15, 502	58, 464	1	2, 671	ū	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	13, 355	32, 593		1, 489	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	5, 096	3, 772	1	172	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 944	7, 887		360	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 083	9, 601	0		0	73.00
74. 00		2, 564	0			0	74. 00
76. 00		265	0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS			1			
91. 00		0	0		· ·	0	
91. 01	04951 OUTPATI ENT THERAPY	0	0	_		0	
93. 00		0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS	_		1			
	09500 AMBULANCE SERVI CES	0		1	· ·	0	
101.00	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117. 00
118. 00	7	163, 152	547, 594	723	24, 773	313, 440	118. 00
	NONREI MBURSABLE COST CENTERS						
	D 19200 PHYSICIANS' PRIVATE OFFICES	1, 038		1	1, 118		192. 00
	0/07950 MARKETI NG	1	34	0	2	-	194. 00
	1 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)	164, 191	572, 111	723	25, 893	313, 440	202. 00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-3042 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am Cost Center Description NURSI NG MEDI CAL Subtotal Intern & Total ADMI NI STRATI ON RECORDS & 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 42, 900 01300 NURSING ADMINISTRATION 13.00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 37, 214 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 785, 354 30.00 03000 ADULTS & PEDIATRICS 42, 900 16, 165 1, 785, 354 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 0 328 974 974 54.00 0 0 05700 CT SCAN 57.00 57 00 O 0 C 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) C 0 0 58.00 60.00 06000 LABORATORY 2, 199 3, 343 0 3, 343 60.00 0000000 06500 RESPIRATORY THERAPY 65.00 1, 277 17, 510 0 0 0 17, 510 65.00 66.00 06600 PHYSI CAL THERAPY 255, 908 255, 908 5, 360 66 00 06700 OCCUPATIONAL THERAPY 67.00 4, 319 148, 947 148, 947 67.00 06800 SPEECH PATHOLOGY 22, 220 22, 220 68.00 1,657 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 505 35, 096 35, 096 71.00 07300 DRUGS CHARGED TO PATIENTS 4, 745 49 406 49, 406 73 00 73 00 07400 RENAL DIALYSIS 0 74.00 659 3, 223 3, 223 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 265 76.00 76.00 265 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 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 09500 AMBULANCE SERVICES 95 00 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 42, 900 SUBTOTALS (SUM OF LINES 1 through 117) 2, 322, 246 37, 214 2, 322, 246 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 99, 091 99, 091 192. 00 0 139 194. 00 194. 00 07950 MARKETI NG 0 C 139

0

42, 900

0

37, 214

0

0

0

2, 421, 476

0 0 0

0 194. 01

0 200. 00 0 201. 00

2, 421, 476 202. 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
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2023

				T	o 12/31/2023		
		CAPITAL REL	_ATED COSTS			4/30/2024 11:	02 alli
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1. 00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	47, 726					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		47, 726				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	192	192	7, 118, 338			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 189	3, 189	1, 747, 652	-4, 416, 883	11, 465, 406	5. 00
7.00	00700 OPERATION OF PLANT	10, 976	10, 976	62, 119	0	1, 056, 921	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	50, 515	8. 00
9. 00	00900 HOUSEKEEPI NG	311	311	169, 873	0	317, 685	9. 00
10.00	01000 DI ETARY	4, 380	4, 380	326, 442	0	854, 601	10.00
13.00	01300 NURSING ADMINISTRATION	501	501	408, 476	0	554, 408	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	520	520	54, 895	0	100, 101	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	19, 476	19, 476	2, 649, 220	0	4, 970, 155	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	0	0	0	0	45, 126	
57. 00	05700 CT SCAN	0	0	0	0	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	79, 880	•
65. 00	06500 RESPI RATORY THERAPY	200	200	102, 785	0	164, 692	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 410		656, 344	0	1, 082, 487	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 901	1, 901	540, 205	0	932, 567	67. 00
68. 00	06800 SPEECH PATHOLOGY	220	220	264, 227	0	355, 869	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	460	460	44, 490		205, 586	1
	07300 DRUGS CHARGED TO PATIENTS	560	560	91, 610		424, 768	•
	07400 RENAL DIALYSIS	0	0	0		179, 014	74.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	18, 477	76. 00
04.00	OUTPATIENT SERVICE COST CENTERS						04.00
	09100 EMERGENCY	0	0	0		0	91.00
	04951 OUTPATIENT THERAPY	0	0	0		0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0	0	0	0	0	93. 00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	o	0	0	0	95. 00
	10100 HOME HEALTH AGENCY			0		_	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0	U U	U	U	U	101.00
117 00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	ol	0	0	0	117. 00
118. 00	l I	46, 296		_			•
110.00	NONREI MBURSABLE COST CENTERS	10, 270	10, 270	7, 110, 000	1, 110, 000	11,072,002	1110.00
192. 00	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 428	1, 428	0	0	72, 452	192. 00
	07950 MARKETI NG	2	2	0			194. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	o	0	0		194. 01
200.00		1]				200.00
201.00	1 1						201.00
202.00		2, 161, 140	260, 336	1, 538, 100		4, 416, 883	
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	45. 282236	5. 454805	0. 216076		0. 385236	203. 00
204.00	Cost to be allocated (per Wkst. B,			9, 741		164, 191	204. 00
	Part II)						
205.00				0. 001368		0. 014321	205. 00
206.00							206. 00
207.00	(per Wkst. B-2)						207 22
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	iaits iii aliu iv)	I	ا ا		ı l		I

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3042

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

4/30/2024 11:02 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (SQUARE FEET) (TOTAL PATIENT ADMINISTRATION PLANT (SQUARE FEET) (TOTAL PATIENT DAYS) (NURSI NG DAYS) SALARI ES) 7.00 8.00 9.00 10.00 13.00 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 33.369 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9, 432 9.00 00900 HOUSEKEEPI NG 311 33, 058 9.00 10.00 01000 DI ETARY 4,380 4, 380 9, 432 10.00 01300 NURSING ADMINISTRATION 2, 649, 220 13.00 13 00 501 C 501 01600 MEDICAL RECORDS & LIBRARY 16.00 520 520 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19, 476 9, 432 19, 476 9, 432 2, 649, 220 30.00 04400 SKILLED NURSING FACILITY 44.00 44 00 0 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 0 0 54.00 0 05700 CT SCAN 0 0 57 00 0 0 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 58.00 06000 LABORATORY 0 0 0 0 0 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 200 200 0 0 0 65.00 0 06600 PHYSI CAL THERAPY Ω 66.00 3 410 3 410 0 66 00 67.00 06700 OCCUPATI ONAL THERAPY 1,901 0 1,901 0 67.00 06800 SPEECH PATHOLOGY 220 220 68.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 460 0 460 0 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73 00 560 Ω 560 0 74.00 07400 RENAL DIALYSIS 0 0 C 0 0 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76.00 76.00 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 91 00 09100 EMERGENCY 0 0 0 0 0 91.01 04951 OUTPATIENT THERAPY 0 0 0 0 0 91.01 93.00 04950 OUTPATIENT WOUND CENTER 93.00 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 31, 939 9, 432 9, 432 2, 649, 220 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 628 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 1.428 1. 428 194. 00 07950 MARKETI NG 0 194. 00 C 2 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 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, 1, 464, 085 69, 975 453, 714 1, 436, 114 796, 844 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 43.875603 7.418893 13. 724787 152. 259754 0. 300784 203. 00 204.00 Cost to be allocated (per Wkst. B, 572, 111 25, 893 313, 440 42, 900 204. 00 723 Part II) Unit cost multiplier (Wkst. B, Part 205.00 17 144985 0.076654 0.783260 33 231552 0. 016193 205. 00 II) 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)

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-3042 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am 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 22, 741, 605 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 875, 250 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 200, 781 54.00 05700 CT SCAN 57.00 57 00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 60.00 06000 LABORATORY 1, 343, 835 60.00 65. 00 06500 RESPIRATORY THERAPY 780, 548 65.00 06600 PHYSI CAL THERAPY 3, 276, 375 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 2, 640, 205 67.00 06800 SPEECH PATHOLOGY 1, 012, 590 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 308, 627 71.00 07300 DRUGS CHARGED TO PATIENTS 2, 900, 644 73.00 73 00 74.00 07400 RENAL DIALYSIS 402, 750 74.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 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 0 95 00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS 117.00 0 22, 741, 605 118.00 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, 168, 616 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.007414 203. 00 204.00 Cost to be allocated (per Wkst. B, 37, 214 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001636 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)

Health Financial Systems Lafaye	tte Regional Re	ehabilitation H	ospi t	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 4/30/2024 11:	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 03000 ADULTS & PEDI ATRI CS	10, 382, 817	I .	10, 382, 81	7 0	10, 382, 817	
44.00 O4400 SKILLED NURSING FACILITY	C)		0	0	44. 00
ANCILLARY SERVICE COST CENTERS	+					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	63, 999		63, 99	9 0	63, 999	
57. 00 05700 CT SCAN	C)		0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C)		0	0	58. 00
60. 00 06000 LABORATORY	120, 616		120, 61		120, 616	
65. 00 06500 RESPI RATORY THERAPY	245, 444	l control of the cont	245, 44		245, 444	
66. 00 06600 PHYSI CAL THERAPY	1, 720, 209	l control of the cont	1, 720, 20		1, 720, 209	
67.00 06700 OCCUPATIONAL THERAPY	1, 420, 898		1, 420, 89		1, 420, 898	
68. 00 06800 SPEECH PATHOLOGY	513, 142		513, 14		513, 142	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	313, 569	l control of the cont	313, 56		313, 569	
73.00 07300 DRUGS CHARGED TO PATIENTS	642, 165	l control of the cont	642, 16		642, 165	
74. 00 07400 RENAL DI ALYSI S	250, 963		250, 96		250, 963	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	25, 595	5	25, 59	5 0	25, 595	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	C	1		0	0	, , , , , ,
91. 01 04951 0UTPATI ENT THERAPY	C)		0	0	
93. 00 04950 OUTPATIENT WOUND CENTER	C)		0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	C	ł .	•	0 0	0	
101.00 10100 HOME HEALTH AGENCY	C)		0	0	101. 00
SPECIAL PURPOSE COST CENTERS			1			
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	C			0		117. 00
200.00 Subtotal (see instructions)	15, 699, 417	0	15, 699, 41	7 0	15, 699, 417	
201.00 Less Observation Beds	C)	' '	0		201. 00
202.00 Total (see instructions)	15, 699, 417	' 0	15, 699, 41	7 0	15, 699, 417	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3042 Peri od: Worksheet C From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am 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 9, 875, 250 9, 875, 250 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 200, 781 200, 781 0.318750 0.000000 54.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 0 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0.000000 58.00 60.00 06000 LABORATORY 1, 343, 835 0 1, 343, 835 0.089755 0.000000 60.00 06500 RESPIRATORY THERAPY 0. 314451 780.548 780, 548 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 2, 368, 715 907, 660 0. 525034 0.000000 66.00 3, 276, 375 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 278, 440 361, 765 2, 640, 205 0.538177 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 821, 210 191, 380 1, 012, 590 0.506762 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 308, 627 0.000000 71.00 308, 627 1.016013 71.00 C 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 900, 644 C 2, 900, 644 0. 221387 0.000000 73.00 74.00 07400 RENAL DIALYSIS 402, 750 402, 750 0.623124 0.000000 74.00 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 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) 21, 280, 800 1, 460, 805 22, 741, 605 200. 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 21, 280, 800 1, 460, 805 22, 741, 605 202.00

				To 12/31/2023	Date/Time Pre 4/30/2024 11:	
			Title XVIII	Hospi tal	47 307 2024 TT. PPS	UZ alli
	Cost Center Description	PPS Inpatient Ratio 11.00		, nespital	.,,	
I	NPATIENT ROUTINE SERVICE COST CENTERS	,				
30.00	03000 ADULTS & PEDIATRICS					30.00
44.00	04400 SKILLED NURSING FACILITY					44.00
A	ANCILLARY SERVICE COST CENTERS					
	D5400 RADI OLOGY-DI AGNOSTI C	0. 318750				54. 00
	D5700 CT SCAN	0. 000000				57. 00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58. 00
	06000 LABORATORY	0. 089755				60.00
	06500 RESPI RATORY THERAPY	0. 314451				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 525034				66. 00
	06700 OCCUPATI ONAL THERAPY	0. 538177				67. 00
	06800 SPEECH PATHOLOGY	0. 506762				68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 016013				71. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 221387				73. 00
	07400 RENAL DI ALYSI S	0. 623124				74. 00
-	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76. 00
	DUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY	0. 000000				91. 00
	04951 OUTPATI ENT THERAPY	0. 000000				91. 01
	04950 OUTPATIENT WOUND CENTER	0. 000000				93. 00
	OTHER REIMBURSABLE COST CENTERS					l
	09500 AMBULANCE SERVI CES	0. 000000				95. 00
<u> </u>	10100 HOME HEALTH AGENCY					101. 00
<u> </u>	SPECIAL PURPOSE COST CENTERS					4
	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

76 00

91.00

91.01

93.00

200.00

201.00

202.00

03950 OTHER ANCILLARY SERVICE COST CENTERS

Subtotal (see instructions)

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

04950 OUTPATIENT WOUND CENTER

SPECIAL PURPOSE COST CENTERS 117. 00 06950 OTHER SPECIAL PURPOSE COST CENTERS

04951 OUTPATIENT THERAPY

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

101.00 10100 HOME HEALTH AGENCY

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15, 699, 417 200. 00

15, 699, 417 202. 00

76 00

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93.00

95.00

0 101.00

0 117. 00

0 201 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3042 Peri od: Worksheet C From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am 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 9, 875, 250 9, 875, 250 30.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 200, 781 200, 781 0.318750 0.000000 54.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 0 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0.000000 58.00 60.00 06000 LABORATORY 1, 343, 835 0 1, 343, 835 0.089755 0.000000 60.00 06500 RESPIRATORY THERAPY 0. 314451 780.548 780, 548 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 2, 368, 715 907, 660 0. 525034 0.000000 66.00 3, 276, 375 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 278, 440 361, 765 2, 640, 205 0.538177 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 821, 210 191, 380 1, 012, 590 0.506762 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 308, 627 0.000000 71.00 C 308, 627 1.016013 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 900, 644 C 2, 900, 644 0. 221387 0.000000 73.00 74.00 07400 RENAL DIALYSIS 402, 750 402, 750 0.623124 0.000000 74.00 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 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) 21, 280, 800 1, 460, 805 22, 741, 605 200. 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 21, 280, 800 1, 460, 805 22, 741, 605 202.00

From 01/01/202 To 12/31/202	
Title XIX Hospital	PPS
Cost Center Description PPS Inpatient	
Rati o	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS	30.00
44.00 04400 SKILLED NURSING FACILITY	44. 00
ANCILLARY SERVICE COST CENTERS	
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0. 318750	54.00
57. 00 05700 CT SCAN 0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000	58. 00
60. 00 06000 LABORATORY 0. 089755	60.00
65. 00 06500 RESPI RATORY THERAPY 0. 314451	65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 525034	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 538177	67. 00
68. 00 06800 SPEECH PATHOLOGY 0. 506762	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.016013	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 221387	73. 00
74. 00 07400 RENAL DI ALYSI S 0. 623124	74.00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS	
91. 00 09100 EMERGENCY 0. 000000	91.00
91. 01 04951 0UTPATI ENT THERAPY 0. 000000	91. 01
93. 00 04950 0UTPATI ENT WOUND CENTER 0.000000	93. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 0. 000000	95. 00
101. 00 10100 HOME HEALTH AGENCY	101. 00
SPECIAL PURPOSE COST CENTERS	
117. 00 06950 0THER 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

 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 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-3042

				10	12/31/2023	4/30/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS						
	RADI OLOGY-DI AGNOSTI C	63, 999	974	63, 025	0	0	54. 00
	CT SCAN	0	C	0	0	0	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	0	C	0	0	0	58. 00
	LABORATORY	120, 616	3, 343	117, 273	0	0	60.00
	RESPI RATORY THERAPY	245, 444	17, 510	227, 934	0	0	65. 00
66.00 06600	PHYSI CAL THERAPY	1, 720, 209	255, 908	1, 464, 301	0	0	66. 00
67. 00 06700	OCCUPATIONAL THERAPY	1, 420, 898	148, 947	1, 271, 951	0	0	67. 00
68.00 06800	SPEECH PATHOLOGY	513, 142	22, 220	490, 922	0	0	68. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	313, 569	35, 096	278, 473	0	0	71. 00
73.00 07300	DRUGS CHARGED TO PATIENTS	642, 165	49, 406	592, 759	0	0	73. 00
74.00 07400	RENAL DIALYSIS	250, 963	3, 223	247, 740	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	25, 595	265	25, 330	0	0	76. 00
OUTPA	ATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	C	0	0	0	91.00
91. 01 0495	OUTPATIENT THERAPY	0	C	0	0	0	91. 01
	OUTPATIENT WOUND CENTER	0	C	0	0	0	93. 00
	R REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0	C	0	0	_	
101. 00 10100	HOME HEALTH AGENCY	0	C	0	0	0	101. 00
	AL PURPOSE COST CENTERS						
117. 00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	C	0	0		117. 00
200.00	Subtotal (sum of lines 50 thru 199)	5, 316, 600	536, 892	4, 779, 708	0		200. 00
201. 00	Less Observation Beds	0	C	0	0		201. 00
202. 00	Total (line 200 minus line 201)	5, 316, 600	536, 892	4, 779, 708	0	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 4/30/2024 | 11: 02 am

						4/30/2024 11:02 am	1
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,				
		Operating Cost	Part I, column	Ratio (col.	6		
		Reduction	8)	/ col . 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	63, 999	200, 781	0. 31875	50	54.0)0
57.00	05700 CT SCAN	0	C	0.00000	00	57.0	00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0.00000	00	58. 0	00
60.00	06000 LABORATORY	120, 616	1, 343, 835	0. 08975	55	60.0	00
65.00	06500 RESPI RATORY THERAPY	245, 444	780, 548	0. 31445	51	65. 0	00
66.00	06600 PHYSI CAL THERAPY	1, 720, 209	3, 276, 375	0. 52503	34	66. 0	00
67.00	06700 OCCUPATI ONAL THERAPY	1, 420, 898	2, 640, 205	0. 53817	77	67. 0	00
68.00	06800 SPEECH PATHOLOGY	513, 142	1, 012, 590	0. 50676	52	68. 0	00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	313, 569	308, 627	1. 01601	13	71. 0	00
73.00	07300 DRUGS CHARGED TO PATIENTS	642, 165	2, 900, 644	0. 22138	37	73.0	00
74.00	07400 RENAL DIALYSIS	250, 963	402, 750	0. 62312	24	74.0	00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	25, 595	C	0. 00000	00	76. 0	00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	C	0.00000	00	91. 0	00
91.01	04951 OUTPATI ENT THERAPY	0	C	0. 00000	00	91. 0) 1
93.00	04950 OUTPATIENT WOUND CENTER	0	C	0. 00000	00	93. 0	00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	C	0.00000	00	95. 0	00
101.00	10100 HOME HEALTH AGENCY	0	C	0. 00000	00	101. 0	00
	SPECIAL PURPOSE COST CENTERS						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0	C	0.00000	00	117. 0	00
200.00	Subtotal (sum of lines 50 thru 199)	5, 316, 600	12, 866, 355	5		200. 0	00
201.00	Less Observation Beds	0	C			201. 0	00
202.00	Total (line 200 minus line 201)	5, 316, 600	12, 866, 355	5		202. 0	00

Health Financial Systems Lafaye	tte Regional Re	habilitation H	lospi t	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 01/01/2023	Worksheet D Part I	
				To 12/31/2023		pared:
					4/30/2024 11:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	T	T				
30. 00 ADULTS & PEDI ATRI CS	1, 785, 354	0	1, 785, 35	9, 432	l	
44.00 SKILLED NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	1, 785, 354		1, 785, 35	4 9, 432		200. 00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	6. 00	6) 7. 00	+			
INDATI ENT DOUTINE CEDVICE COCT CENTERC	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	4 701	000.053				20.00
30. 00 ADULTS & PEDIATRICS	4, 701	889, 852				30.00
44.00 SKILLED NURSING FACILITY	4 701	000.053	,			44. 00
200.00 Total (lines 30 through 199)	4, 701	889, 852	<u>'</u>			200. 00

Health Financial Systems	Lafayette Regional F	Rehabilitation Hospit	In Lie	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SER	RVICE CAPITAL COSTS	Provi der CCN: 15-3042	From 01/01/2023	Worksheet D Part II Date/Time Prepared: 4/30/2024 11:02 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	Capi tal	Total Charges Ratio of (ost Inpatient	Capital Costs

				To 12/31/2023	Date/Time Pre 4/30/2024 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· ·		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T .		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	974	200, 781		· ·	473	
57. 00 05700 CT SCAN	0	0	0.00000		0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0. 00000		0	58. 00
60. 00 06000 LABORATORY	3, 343			· ·		60.00
65. 00 06500 RESPI RATORY THERAPY	17, 510		1			
66. 00 06600 PHYSI CAL THERAPY	255, 908					
67. 00 06700 OCCUPATI ONAL THERAPY	148, 947	2, 640, 205	1			
68.00 06800 SPEECH PATHOLOGY	22, 220					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35, 096		1	· ·		
73.00 O7300 DRUGS CHARGED TO PATIENTS	49, 406	2, 900, 644				
74. 00 07400 RENAL DI ALYSI S	3, 223	•	1		1, 994	74.00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	265	0	0. 00000	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	0. 00000	0	0	91. 00
91. 01 04951 0UTPATI ENT THERAPY	0	0	0. 00000	0	0	91. 01
93. 00 O4950 OUTPATIENT WOUND CENTER	0	0	0. 00000	0 0	0	93. 00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES					I	95. 00
200.00 Total (lines 50 through 199)	536, 892	12, 866, 355		5, 835, 117	220, 514	200. 00

Health Financial Systems Lafayer	te Regional Re	habilitation H	ospi t	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST		<u> </u>	Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre 4/30/2024 11:	pared: 02 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health		
	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	o	0	1	0		44.00
200.00 Total (lines 30 through 199)	o	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						
30, 00 03000 ADULTS & PEDIATRICS	0	0	9, 432	0.00	4, 701	30.00
44.00 04400 SKILLED NURSING FACILITY	_	0		0.00		
200.00 Total (lines 30 through 199)		0	9, 43		l .	200. 00
Cost Center Description	Inpati ent	J	77 10.	=	.,,,,,,	200.00
0001 0011101 20001 1 pt 1 011	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7. 00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY						44. 00
200.00 Total (lines 30 through 199)	0					200. 00
200.00 Total (Tries 30 till ough 199)	ı Y					1200.00

Health Financial Systems Lafa	ette Regional Re	ehabilitation H	ospi t	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PASS	S Provider Co	CN: 15-3042	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 4/30/2024 11:0	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		

					4/30/2024 11.1	UZ aiii
		Titl∈	XVIII	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 I MAGING (MRI)	0	0) (0	0	58. 00
60. 00 06000 LABORATORY	0	0) (0	0	60.00
65. 00 06500 RESPIRATORY 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 DIALYSIS	0	0) (0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0) (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]
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)	0	0) (0	0	200. 00
	•	•	•	•		-

	Financial Systems Lafaye I ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	tte Regional Re			In Lie Period:	u of Form CMS- Worksheet D	2552-10
	H COSTS	WICE OTHER TAGE	, Trovider co				
TTIKOOC	11 60313				From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
						4/30/2024 11:	02 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		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		0 200, 781	0. 000000	
57. 00	05700 CT SCAN	0	0		0	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0. 000000	
	06000 LABORATORY	0	0		0 1, 343, 835	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 780, 548	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 3, 276, 375	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 640, 205	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 1, 012, 590	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 308, 627	0.000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 900, 644	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 402, 750	0.000000	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	O	0		0 0	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	0		0 0	0.000000	91. 00
91.01	04951 OUTPATIENT THERAPY	O	0		0 0	0.000000	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	o	0		0 0	0.000000	93. 00
	OTHER REIMBURSABLE COST CENTERS	•					1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 12, 866, 355		200.00

Health Financial Systems Lafayette Regional Rehabilitation Hospit In Lieu of Form CMS-2552-10							
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS			CN: 15-3042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 4/30/2024 11:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through		Outpatient Program Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS	TT				_	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	97, 514		0	0	54.00
57. 00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0	0	58. 00
60.00	06000 LABORATORY	0. 000000	692, 086		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	437, 096		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 207, 875		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 146, 310		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	375, 205		0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	119, 089		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1, 510, 792		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0.000000	249, 150		0	0	74.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 00
01 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	0.000000					01 00
91.00		0.000000	0		0	1	91.00
91. 01	04951 OUTPATIENT THERAPY	0.000000	0		0	0	91. 01
93. 00	04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	0	93. 00
05.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES						05 00
95. 00 200. 00			5, 835, 117		0 0	0	95. 00 200. 00

Heal th	Financial Systems Lafaye	tte Regional Re	habilitation H	ospi t	In Li€	eu of Form CMS-2	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2023 To 12/31/2023		nared·
					12/01/2020	4/30/2024 11:	
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		4.00	0.00	(see inst.)	(see inst.)		
	ANOLILIARY CERVI OF COCT OFNITERS	1. 00	2.00	3. 00	4. 00	5. 00	
F4 00	ANCI LLARY SERVI CE COST CENTERS	0.210750					F4 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 318750			0	0	54. 00 57. 00
57. 00	05700 CT SCAN	0. 000000	-		0	_	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	-		0	0	58. 00
60.00	06000 LABORATORY	0. 089755	-		0	0	60.00
65. 00	06500 RESPIRATORY THERAPY	0. 314451			0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 525034			0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 538177			0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 506762			0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 016013			0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 221387			0	0	73.00
	07400 RENAL DIALYSIS	0. 623124			0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 00
01 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0.000000	1 0				01 00
91. 00 91. 01	04951 OUTPATIENT THERAPY	0. 000000 0. 000000			0	0	91. 00 91. 01
	04950 OUTPATIENT THERAPY	0. 000000			0 0	0	
93.00	OTHER REIMBURSABLE COST CENTERS	0.000000	<u> </u>		0 0	U	93.00
95. 00	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
200.00		0.000000	0		0	_	200.00
200.00	1 /						200.00
201.00	Only Charges				0		201.00
202.00			0		0 0	0	202. 00
202.00	inet sharges (Trile 200 Trile 201)	I	1	ı	Ο Ι	1	1202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	J VACCINE COST	Provider Co	CN: 15-3042	From 01/01/2023 To 12/31/2023	Part V Date/Time Pre 4/30/2024 11:	
		Title	XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	†			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	1			
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 RESPIRATORY 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	2			74.00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0)			76. 00
91. 00 09100 EMERGENCY	0	0	N .			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	<u> </u>		1			70.00
95. 00 09500 AMBULANCE SERVI CES	0					95. 00
200.00 Subtotal (see instructions)	O	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0)			202. 00

Health Financial Systems Lafaye	tte Regional Re	habilitation H	ospi t	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				rom 01/01/2023		
				Γο 12/31/2023		pared:
		T' 11	V/1 V/		4/30/2024 11:	<u>02 am</u>
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 785, 354	0	1, 785, 354	9, 432	189. 29	30.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44.00
200.00 Total (lines 30 through 199)	1, 785, 354		1, 785, 354	9, 432		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	•		•			
30. 00 ADULTS & PEDI ATRI CS	42	7, 950				30.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (Lines 30 through 199)	42	7. 950				200.00

Health Financial Systems	Lafayette Regional R	Rehabilitation Hospit	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERV	TICE CAPITAL COSTS	Provider CCN: 15-3042	Peri od: From 01/01/2023	Worksheet D Part II

APPORT	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider Co	Provi der CCN: 15-3042		Worksheet D Part II Date/Time Pre 4/30/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
			(from Wkst. C,			(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
54. 00	05400 RADI OLOGY-DI AGNOSTI C	974	200, 781	l .		4	54. 00
57. 00	05700 CT SCAN	0	0	0. 00000		0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000		0	58. 00
60.00	06000 LABORATORY	3, 343		l .	•		
65. 00	06500 RESPI RATORY THERAPY	17, 510	780, 548	l .		10	65. 00
66. 00	06600 PHYSI CAL THERAPY	255, 908					
67. 00	06700 OCCUPATI ONAL THERAPY	148, 947	2, 640, 205	•			
68. 00	06800 SPEECH PATHOLOGY	22, 220					
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35, 096					
73.00	07300 DRUGS CHARGED TO PATIENTS	49, 406			•	177	73. 00
	07400 RENAL DI ALYSI S	3, 223	402, 750			0	,
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	265	0	0.00000	00 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
91. 00	09100 EMERGENCY	0	0	0. 00000		0	, 00
91. 01	04951 OUTPATI ENT THERAPY	0	0	0. 00000		0	91. 01
93. 00	04950 OUTPATIENT WOUND CENTER	0	0	0.00000	00 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	536, 892	12, 866, 355		45, 496	2, 129	200. 00

Health Financial Systems La	fayette Regional Reh	nabilitation H	ospi t	In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	ER PASS THROUGH COST	S Provider CO	F	Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	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		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	C	0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0	C	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.	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 & PEDIATRICS	0	0	9, 432	0.00	42	30.00
44.00 04400 SKILLED NURSING FACILITY		0	C	0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	9, 432	2	42	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 & PEDI ATRI CS	0					30. 00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	Lafayette Regional Re	habilitation H	ospi t	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	S Provider CC		Peri od: From 01/01/2023 To 12/31/2023	Date/Time Prep	
		Ti tl	e XIX	Hospi tal	4/30/2024 11: 0 PPS	02 am_
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursi ng Program	Allied Health Post-Stepdown		

					17 007 202 1 11.	0 <u>2</u> am
		Titl	e XIX	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	
ANCILLARY SERVICE 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		0	(0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	(0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0	(0	0	73. 00
74.00 07400 RENAL DIALYSIS	C	o o		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 0UTPATIENT THERAPY		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 SERVICES						95. 00
200.00 Total (lines 50 through 199)	C	0	(0	0	200.00
	•	•	•	1	•	

		tte Regional Re				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider CO		Peri od: From 01/01/2023	Worksheet D Part IV	
THRUUG	H COSTS				To 12/31/2023		epared:
						4/30/2024 11:	02 am
			Ti tl	e XIX	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		$(col. 5 \div col.$	
			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		0 200, 781	0. 000000	
57.00	05700 CT SCAN	0	0		0	0. 000000	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0.000000	
60.00	06000 LABORATORY	0	0		0 1, 343, 835	0. 000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 780, 548	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 3, 276, 375	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 640, 205	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 1, 012, 590	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 308, 627	0.000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 900, 644	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 402, 750	0.000000	74. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	0		0 0	0.000000	91. 00
91. 01	04951 OUTPATI ENT THERAPY	0	0		0 0	0.000000	91. 01
93.00	04950 OUTPATIENT WOUND CENTER	0	0		0 0	0.000000	93. 00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	o	0		0 12, 866, 355		200.00

Heal th	Financial Systems Lafaye	tte Regional Rel	habilitation H	ospi t	In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS			CN: 15-3042 P	eriod: rom 01/01/2023 o 12/31/2023		pared: 02 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col . 6 ÷ col .		Costs (col. 8		Costs (col. 9	
		7) 9.00	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCI LLARY SERVI CE COST CENTERS	9.00	10. 00	11.00	12.00	13.00	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	786		0	0	54.00
57. 00	05700 CT SCAN	0.000000	760 0		0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58.00
60.00	06000 LABORATORY	0.000000	5, 044		0		60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	432		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	8. 195		86, 905	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	11, 570		58, 730		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	4, 330	C	16, 380		68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 724	C	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	10, 415	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 OUTPATI ENT 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)		45, 496	[c	162, 015	0	200. 00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Period: From 01/01/2023 To 12/31/2023		
			Ti tl	e XIX	Hospi tal	PPS	02 0
				Charges		Costs	
	Cost Center Description	Cost to Charge	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.	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. 318750	0		0 0	0	54.00
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0	0	58. 00
60.00	06000 LABORATORY	0. 089755			0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 314451	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 525034	86, 905		0 0	45, 628	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 538177	58, 730		0 0	31, 607	67.00
68.00	06800 SPEECH PATHOLOGY	0. 506762	16, 380		0 0	8, 301	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 016013	0		0 0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 221387	0		0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0. 623124	0		0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0. 000000			0	0	
	04951 OUTPATI ENT THERAPY	0. 000000			0	0	
93. 00	04950 OUTPATIENT WOUND CENTER	0. 000000	0		0 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS		,				
	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
200.00			162, 015		0	85, 536	
201.00					0		201. 00
	Only Charges		4.0		-	0= ==:	
202.00	Net Charges (line 200 - line 201)		162, 015		0	85, 536	202. 00

From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 4/30/2024 11:02 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Reimbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 57.00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 60. 00 06000 LABORATORY 0 60.00 65. 00 06500 RESPIRATORY THERAPY 65.00 66. 00 |06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 0 91.00 09100 EMERGENCY 0 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 0 200.00 Subtotal (see instructions) 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	Lafayette Regional Rehabilitation Hospit In Lieu				2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3042	Peri od: From 01/01/2023	Worksheet D-1	
				Date/Time Pre 4/30/2024 11:	
		Title XVIII	Hospi tal	PPS	

		T: +1 o V/// / /	Hooni tal	4/30/2024 11:0	02 am	
	Cost Center Description	Title XVIII	Hospi tal	PPS		
	,			1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	e eveluding newhorn)		9, 432	1.00	
2. 00	Inpatient days (including private room days, excluding swing-led days)			9, 432	2.00	
3. 00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00	
	do not complete this line.		-			
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	9, 432	4.00	
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5. 00	
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	0	6. 00	
	reporting period (if calendar year, enter 0 on this line)					
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00	
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	days) after December 3	1 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei 3	i oi the cost	٥	0.00	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	4, 701	9. 00	
	newborn days) (see instructions)	0 .				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00	
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00	
11.00	December 31 of the cost reporting period (if calendar year, en		days) arter	١	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00	
40.00	through December 31 of the cost reporting period				40.00	
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			0	13. 00	
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00	
15.00	Total nursery days (title V or XIX only)	, 3	,	0	15. 00	
16. 00	Nursery days (title V or XIX only)	0	16. 00			
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	0.00	17 00			
17. 00	reporting period	0. 00	17. 00			
18. 00	Medicare rate for swing-bed SNF services applicable to service	0. 00	18. 00			
	reporting period					
19. 00	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	after December 31 of t	he cost	0. 00	20. 00	
20.00	reporting period	arter becomber 31 01 t	110 0031	0.00	20.00	
21. 00	Total general inpatient routine service cost (see instructions			10, 382, 817	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 6	0	23. 00	
23.00	x line 18)	31 of the cost reportin	g perrou (Trile o	١	23.00	
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00	
	7 x line 19)			ا		
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 382, 817	27. 00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	31. 00	
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0. 00	32. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)				33. 00	
34. 00					34.00	
35. 00 36. 00					35. 00 36. 00	
37. 00					37. 00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUENTO				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		T	1 100 01	20 00	
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 100. 81 5, 174, 908	38. 00 39. 00	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40.00	
41. 00						

		tte Regional Re	habilitation H			eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	UN: 15-3042	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 4/30/2024 11:	pared:
			Title	xVIII	Hospi tal	PPS	OZ alli
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	col . 2)	÷	(col. 3 x col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT						43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
17. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
18. 00	Program inpatient ancillary service cost (Wks	s+ D 2 col 3	2 line 200)			1. 00 2, 282, 596	48. 00
	Program inpatient cellular therapy acquisition			III line 10	column 1)	2, 202, 590	48. 01
	Total Program inpatient costs (sum of lines 4				cordiiir 1)	7, 457, 504	
	PASS THROUGH COST ADJUSTMENTS			•		.,,	1
0. 00						889, 852	50. 00
1. 00						220, 514	51. 00
2. 00	and IV) 					1, 110, 366	52. 00
						6, 347, 138	
	medical education costs (line 49 minus line 52)					2, 211, 120	1
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	54.00
	Program discharges Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor u	use only)				l e	55. 02
6. 00	Target amount (line 54 x sum of lines 55, 55.					0.00	1
57. 00	Difference between adjusted inpatient operati	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	57. 00
8. 00	Bonus payment (see instructions)					0	
9. 00	Trended costs (lesser of line 53 ÷ line 54, (or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	59. 00
50. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year c	ost report, u	updated by the	0.00	60.00
	market basket)			•			
51. 00	Continuous improvement bonus payment (if line					0	61. 00
	55.01, or line 59, or line 60, enter the less						
	53) are less than expected costs (lines 54×10^{-2} enter zero. (see instructions)	ou), or 1 % of	ine target am	iount (Tine 56	o), otnerwise		
2. 00	Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			ő	
	PROGRAM INPATIENT ROUTINE SWING BED COST	,	,				
4. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	ts after Decemb	oer 31 of the c	ost renorting	n period (See	0	65. 00
5. 50	instructions)(title XVIII only)	to dittor becenik	o. or or the c	ost reportini	, perrou (see		03.00
6. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line 6	5)(title XVII	I only); for	0	66. 00
7.60	CAH, see instructions					_	/7.00
7. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	ı vecember 31 o	or the cost re	eporting period	0	67. 00
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after [December 31 of	the cost repo	orting period	0	68. 00
	(line 13 x line 20)			•		I	1

1.00 2.00 3.00 4.00 5.00 4.7.0 4			inpatient cost	Inpatient Days			(col. 3 x col.	
			1 00	2 00	col. 2)	4 00	4) 5.00	
Interestive Care Type Impatitumit Respit tal Binits	42 00	NURSERY (title V & XLX only)	1.00	2.00	3.00	4.00	3.00	42. 00
43.00	12.00							12.00
45.00 SIRRIC FITESTRY CARE UNIT	43.00							43.00
4-0.00 Cost Centrer Description 4-0.00 Cost Centrer Descri	44.00	CORONARY CARE UNIT						44. 00
17.00 OTHER SPECIAL CARE (SPECIFY)	45.00	BURN INTENSIVE CARE UNIT						45. 00
Cost Center Description	46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
1.00	47. 00							47. 00
Response Program Inpattient ancillary service cost (West. D-3, Col. 3, Line 200) 2, 28,2,566 48, 00 Program Inpattient costs (sum of lines 41 through 48.01) (see instructions) 2, 28,2,566 48, 00 Program Inpattient costs (sum of lines 41 through 48.01) (see instructions) 2, 28,2,566 48, 00 Program Inpattient costs (sum of lines 41 through 48.01) (see instructions) 2, 28,2,566 48, 00 Program Inpattient costs (sum of lines 41 through 48.01) (see instructions) 2, 28,2,566 48, 00 Program Inpattient costs 2, 20, 20, 20 Program Inpattient 2, 20, 514 51.01 20, 20, 20 20, 20, 20 20,		Cost Center Description					1.00	
Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	40.00	Danage :	-+ D 21 2	2 11 200)				40.00
49.00 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 7,497.504 49.00					III line 10	column 1)		
Poss THROUGH COST ADJISTMENTS						corumir 1)		
50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 1970) Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 220, 514 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 220, 514 51.00 Pass through costs (sum of lines 50 and 51) 1.110, 366 52.00 Pass through cost sext using capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52) Pass through costs (line 50 minus line 52) Pass through costs (line 50 minus line 53) Pass through costs (line 50 minus line 50 mi	47.00	9 1 '	41 thi ough 40. C	or) (see Tristrac	. (1 0113)		7, 437, 304	47.00
1110 Seas through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II 220, 514 51.00 and IV) 17.00	50.00		atient routine	services (from	Wkst. D. sum	of Parts I and	889, 852	50.00
and IV) 1. 10. 366 \$2.00 Total Program excludable cost (sum of lines 50 and 51) \$1.00				•	·			
1,110,366 52.00 10 10 10 10 10 10 10	51.00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	220, 514	51.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and rediction costs (line 40 minus line 52)								
medical education costs (line 49 minus line 52)								
TARGET MOUNT AND LIMIT COMPUTATION	53. 00			elated, non-phy	sician anesthe	tist, and	6, 347, 138	53. 00
54.00 Program discharges 0 0 54.0			52)				L	
55.00 Target amount per discharge 55.01 Permanent adjustment amount per discharge 55.01 Permanent adjustment amount per discharge 55.02 Adjustment amount per discharge (contractor use only) 55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 58) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 58) 59.00 Difference costs (line 53 + line 54, or line 55 from prior year cost reporting period ending 1996, market basket) 60.00 Difference costs (line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 60.00 Difference costs (line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 60.00 Difference costs (line 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see Instructions) 60.00 Difference costs (line 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see Instructions) 60.00 Difference sain q-bed SWF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 60.00 Difference sain q-bed SWF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 60.00 Difference sain q-bed SWF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 60.01 Difference sain q-bed SWF inpatient routine costs (line 67 + line 68) 60.01 Difference pages to benefic arise for excess costs (line 67 + line 69) 60.01 Difference pa	54.00							54.00
Social Process Soci								
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0 56.00 57.00 Borus payment (see instructions) 0 57.00 58.00 Borus payment (see instructions) 0 58.00 58.00 58.00 59.00 Trended costs (clesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 1.0			use onlv)					
S8 00 Bonus payment (see instructions) 0 88 00 99 00 Treded costs (closer of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0 0 0 0 0 0 0 0 0)			0	56. 00
59.00 Trended costs (lesser of line 54 or line 55 from the cost reporting period ending 1996. 0.00 \$9.00 updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Microse by the first payment (see instructions) 65.00 Microse by the decreasing period (see instructions) (litle XVIII only) 65.00 Microse swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/forther nursing facility/fo	57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	57. 00
updated and compounded by the market basket) 0.00 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 1.00 61	58.00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '					0	58. 00
60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55,01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 0 62.00 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 64.00 Michael Lesser of See 10 Cost	59. 00		or line 55 from	n the cost repo	rting period e	ndi ng 1996,	0.00	59. 00
market basket) 1.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive payment (see instructions) 4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (Lite XVIII only) 6.50 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (Lite XVIII only) 6.50 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions) (Lite XVIII only) 6.50 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 6.50 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 6.50 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 6.50 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 6.50 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.50 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.50 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 6.50 Total title V or XIX swing-bed NF inpatient routine service cost (line 68) 6.50 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 6.50 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 6.50 PART III - SKILLED NURSING RECILLITY. AND INFORM FACILITY. AND INFORM FACILITY. AND INFORM FACILITY. AND INFORM FACILITY. AND	(0.00		55 6					
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71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	70 00							70 00
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77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Oscillation (line 78 minus line 79) 89. 00 80. 00								
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		· · · · · · · · · · · · · · · · · · ·	. *					
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81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Pogram inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		99 9	, ,		,	s line 70)		
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 89.00 Reasonable inpatient routi				rimi tati Uli	. Trine 70 minu.	- 11110 ///		81.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 84.00 85.00 85.00 85.00 85.00 86.00 87.00 88.00 88.00				1)				82. 00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Research 88.00 Resea		•		* .				83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 88.00								84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	85. 00	Utilization review - physician compensation	(see instructio	ons)				85. 00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88.00 0.00 88.00	86.00			nrough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	07							
				1: 0)			1	
07. 00 ODSet vali Off Ded COSt (Title of X Title oo) (See Histractions)							1	1
	07.00	longer ration her cost (Time of X Time 88) (Se	e ilisti ucti ulis)	1			0	L 07. UU

Health Financial Systems Lafa	vette Regional I	Rehabilitation H	lospi t	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der 0		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XVIII	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	I COST					
90.00 Capital -related cost	1, 785, 35	10, 382, 81	0. 17195	3 0	0	90. 00
91.00 Nursing Program cost		0 10, 382, 817	0.00000	0 0	0	91. 00
92.00 Allied health cost		0 10, 382, 817	0.00000	0 0	0	92. 00
93.00 All other Medical Education		0 10, 382, 817	0. 00000	0 0	0	93. 00

Health Financial Systems	Lafayette Regional	Rehabilitation Hospit	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-30	42 Period: From 01/01/2023	Worksheet D-1	
				Date/Time Pre 4/30/2024 11:	
		Title XIX	Hospi tal	PPS	
Cost Contor Doscription			· ·		

		Title XIX	Hospi tal	4/30/2024 11: (PPS	02 am_
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			9, 432	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day		vate room days,	9, 432 0	2. 00 3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		9, 432	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period		31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December 3	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	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	42	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yellow Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	0 Nursery days (title V or XIX only) SWING BED ADJUSTMENT				16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00				0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
20. 00					20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		10, 382, 817	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (Tino 21 minus lino 26)		0 10, 382, 817	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Title 21 millus Title 20)		10, 302, 017	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0. 000000	30. 00 31. 00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ± Average private room per diem charge (line 29 ± line 3)	- TITIE 20)		0.00000	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	nus line 33)(see instruc	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line			10, 382, 817	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 100. 81	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			46, 234	39. 00
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		46, 234	41. 00

		te Regional Re				eu of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-3042	Period: From 01/01/2023	Worksheet D-1	
					To 12/31/2023	Date/Time Pre 4/30/2024 11:	
			Ti tI	e XIX	Hospi tal	PPS	UZ alli
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient 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			Ι			43. 00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
	Program inpatient ancillary service cost (Wks			10	1 1)	20, 670	1
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines 4				column I)	0 66, 904	
	PASS THROUGH COST ADJUSTMENTS	rr em sagn ren	, , , (000 1 1 10 tr uc	, , , , , , ,		00,701	1
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	m of Parts I and	7, 950	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	2, 129	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				10, 079	52. 00
53. 00	, ,					56, 825	1
	TARGET AMOUNT AND LIMIT COMPUTATION						1
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge						55. 01
55. 02	Adjustment amount per discharge (contractor u	use only)				0.00	
56. 00	Target amount (line 54 x sum of lines 55, 55.				>	0	
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	irget amount (I	ine 56 minus	line 53)	0	
	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	ortina period	endi na 1996.	0.00	
07.00	updated and compounded by the market basket)						
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year o	cost report, u	updated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
	53) are less than expected costs (lines 54 x		,		,		
(2.00	enter zero. (see instructions)						(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment	ent (see instri	ıctions)			0	
03. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	cht (acc matre	1011 0113)				03.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	g period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (line	64 plus line 6	55)(title XVII	ll only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after [ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient i					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				\		70.00
70.00	Adjusted general inpatient routine service of	•		, ,	,		71.00
72. 00	Program routine service cost (line 9 x line 7			•			72. 00
73.00	Medically necessary private room cost applica	blo to Drogram	. (lina 14 v li	25)		l .	73.00

Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73) 73. 00 73. 00 74.00 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 76.00 Per diem capital-related costs (line 75 ÷ line 2) 76.00 77.00 Program capital-related costs (line 9 x line 76) 77.00 78.00 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 84.00 Utilization review - physician compensation (see instructions)

Total Program inpatient operating costs (sum of lines 83 through 85) 85.00 85.00 86.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 0 87.00 0.00 88.00 88.00 0 89.00 89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems Lafa	ette Regional f	Rehabilitation	Hospi t	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der (Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 4/30/2024 11:	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21) column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	1 COST					
90.00 Capital-related cost	1, 785, 35	10, 382, 81	7 0. 17195	3 0	0	90.00
91.00 Nursing Program cost		0 10, 382, 81	7 0.00000	0 0	0	91.00
92.00 Allied health cost		0 10, 382, 81	7 0. 00000	0	0	92. 00
93.00 All other Medical Education		0 10, 382, 81	7 0. 00000	0 0	0	93. 00

	Financial Systems Lafayette Regional Rehal				u of Form CMS-2	
INPATIE	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-3042	Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narodi
				10 12/31/2023	4/30/2024 11:	
		Title	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description		Ratio of Cos		Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				- The state of the	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			4, 936, 050		30. 00
	ANCILLARY SERVICE COST CENTERS					
	05400 RADI OLOGY-DI AGNOSTI C		0. 3187		31, 083	ł
	05700 CT SCAN		0.00000		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	58. 00
	06000 LABORATORY		0. 0897			60.00
	06500 RESPI RATORY THERAPY		0. 3144			
	06600 PHYSI CAL THERAPY		0. 5250			1
	06700 OCCUPATI ONAL THERAPY		0. 5381			1
	06800 SPEECH PATHOLOGY		0. 5067	· ·		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 0160	· ·		1
	07300 DRUGS CHARGED TO PATIENTS		0. 2213			1
	07400 RENAL DIALYSIS		0. 62312		155, 251	1
	03950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000	00 0	0	76. 00
	OUTPAȚI ENT SERVI CE COST CENTERS					
	09100 EMERGENCY		0.00000		0	
	04951 OUTPATI ENT THERAPY		0.00000		0	
	04950 OUTPATIENT WOUND CENTER		0.0000	00 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			5, 835, 117		
201.00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0	1	201. 00
202.00	Net charges (line 200 minus line 201)			5, 835, 117		202. 00

	Financial Systems Lafayette Regional Rehal ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	eu of Form CMS-2 Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONWENT	Provider C	UN. 13-3042	From 01/01/2023	WOLKSHEEL D-3	
				To 12/31/2023	Date/Time Pre	pared:
					4/30/2024 11:	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			44, 100		30.00
	ANCILLARY SERVICE COST CENTERS		1			
	05400 RADI OLOGY-DI AGNOSTI C		0. 31875			54.00
	05700 CT SCAN		0.00000		0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	58.00
60.00	06000 LABORATORY		0. 08975			60.00
65.00	06500 RESPI RATORY THERAPY		0. 31445			65.00
	06600 PHYSI CAL THERAPY		0. 52503			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 53817			67.00
	06800 SPEECH PATHOLOGY		0. 50676	.,		68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 01601			
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 22138		2, 306	73.00
	07400 RENAL DI ALYSI S		0. 62312		0	74.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0. 00000	00	0	76.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY		0. 00000		0	91.00
91. 01	04951 OUTPATI ENT THERAPY		0.00000	00	0	91. 01
93.00	04950 OUTPATIENT WOUND CENTER		0.00000	00	0	93.00
	OTHER REIMBURSABLE COST CENTERS					
05 00	DOEGO AMBULANCE CERVILCES					

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

95.00

20, 670 200. 00 201. 00 202. 00

45, 496

45, 496

95. 00 09500 AMBULANCE SERVICES

200.00

201. 00 202. 00

Health Financial Systems	Lafayette Regional Rehab	oilitation Hospit	In Lie	u of Form CMS-2552-10
CALCULATION OF DELMDIDSEMENT SETTLEMENT		Providor CCN: 15 2042	Pori od:	Workshoot F

| Provider CCN: 15-3042 | Period: | Worksheet E | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 4/30/2024 | 11: 02 am | Provider CCN: 15-3042 | Period: | Worksheet E | Part B | Date/Time Prepared: | 4/30/2024 | 11: 02 am | Provider CCN: 15-3042 | Period: | Period: | Part B | Date/Time Prepared: | Provider CCN: 15-3042 | Period: | Period: | Part B | Provider CCN: 15-3042 | Period: | Period: | Period: | Part B | Provider CCN: 15-3042 | Period: | Period: | Period: | Part B | Part B | Provider CCN: 15-3042 | Period: | Period: | Part B | Part B

		T: 11 NO.111		4/30/2024 11:0	02 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		0	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)			0	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)			0	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	5. 00
6.00	Line 2 times line 5	,		0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00	Ancillary service other pass through costs including REH direc	t graduate medical educa	ation costs from	0	9. 00
10. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	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, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for p	ayment for services on	charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	3	9	0	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 onl	y if line 18 exceeds lir	ne 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete onl	v if line 11 eveneds lin	20 10) (000	0	20. 00
20.00	instructions)	y II IIIle II exceeds III	le 10) (See	U	20.00
21. 00	Lesser of cost or charges (see instructions)			0	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•	unti ana)	0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			0	26. 00 27. 00
27.00	instructions)	ius the sum of filles 22	and 23] (See	U	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)				28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00	Subtotal (sum of lines 27, 28, 28.50 and 29)			0	30. 00
31. 00	Primary payer payments			0	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	FS)		U	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	L3)		0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	36. 00
37. 00	Subtotal (see instructions)			0	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0	39. 00 39. 50
39. 30	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount (see First detrois)			0	39. 97
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruct	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions)			0	40. 00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			0	40. 03 41. 00
41. 01	Interim payments Interim payments-PARHM			O	41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			0	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)			0	43. 01
44. 00					44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00	The rate used to calculate the Time Value of Money			0. 00	92. 00
93. 00	Time Value of Money (see instructions)			0	93. 00

Health Financial Systems	Lafayette Regional	Rehabilitation Hospit	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3042	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				4/30/2024 11:	02 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems

Lafayette Regional Rehabilitation Hospit

In Lieu of Form CMS-2552-10

Provider CCN: 15-3042

Period:
From 01/01/2023
To 12/31/2023

Part I
Date/Time Prepared:
4/30/2024 11: 02 am

Provider CCN: 15-3042

From 01/01/2023
To 12/31/2023

From 01/01/2023
To

3. 03 3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 4. 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) Tentarive To Provider 5. 01 Extractive To Program 5. 01 Frovider to Program 6. 00 Provider to Program 0			Title	XVIII	Hospi tal	PPS	
Total interim payments paid to provider			I npati en	t Part A	Par	t B	
Total interim payments paid to provider							
Total interim payments paid to provider 8,551,153							
Interin payments payable on individual bills, either Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered in the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero Services rendered in the cost reporting period. Also show date of each payment. If none write "NONE" or enter a zero Services rendered Serv	1 00	Total interior comments and to provide	1.00		3. 00		1 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							
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2.00			0		0	2.00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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)	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment. If none, write 'NONE' or enter a zero. (1)							
Program to Provider							
ADJUSTMENTS TO PROVIDER			<u> </u>				
3. 03 3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 52 3. 53 3. 54 3. 99 4. 00 4. 00 5. 52 5. 50 5. 5	3. 01			0		0	3. 01
3.04 0 0 3.04 3.05				o o			3. 02
3.04 0 0 3.04 3.05	3. 03			0		0	3. 03
Provider to Program 0							3. 04
3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 50 3. 51 3. 52 0 0 0 3. 51 3. 53 3. 54 0 0 0 3. 53 3. 54 0 0 0 3. 53 3. 50 3. 50 0 0 3. 53 3. 50 3. 50 0 0 3. 53 3. 50 3. 50 0 0 3. 53 3. 50 3. 50 3. 50 0 0 3. 53 3. 50 3. 50 3. 50 0 0 3. 53 4. 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. E or Wist. E-3, line and column as appropriate) Total interim payments (sum of lines 1, 2, and 3.99) 8, 551, 153 0 4. 00 5. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 5. 50 5. 00 Determined net settlement amount (balance due) based on the cost report. (1) 15. 52 5. 99 5. 50 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 0 0 5. 52 5. 00 Determined net settlement amount (balance due) based on the cost report. (1) 15. 323 0 6. 01 6. 01 SETTLEMENT TO PROGRAM 0 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) 8, 707, 476 0 0 Contractor NPR Date Number (Mo/Day/Yrr) 1. 0 1 1 1 1 1 1 1 1 1	3. 05			0		ol	3. 05
3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 50		Provider to Program	·				
3.52 3.53 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER TENTATIVE TO PROGRAM TO T	3.50			0		0	3.50
3.53 3.54 3.59 3.594 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.00 TENTATIVE TO PROVIDER 5.00 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 5.50 5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) FOR COMPLETED BY CONTRACTOR 156, 323 0 0 0 0 5.02 0 0 0 0 5.52 0 0 0 0 0 5.52 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 0 5.52 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.51			0		0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1. 2, and 3.99) 8.551.153 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52			0		0	3. 52
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 8,551,153 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3.53			0		0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.54			0		0	3. 54
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5.02 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 7.00 Total Medicare program liability (see instructions) 8,551,153 0 0 4.00 4.00 4.00 4.00 4.00 4.00 Explored to Program 5.50 5.01 0 0 5.50 6.00 5.50 6.00 0 0 0 5.50 6.00 0 0 0 0 5.50 6.00 0 0 0 0 5.50 6.00 0 0 0 0 5.50 6.00 0 0 0 0 0 5.50 6.00 0 0 0 0 0 5.50 6.00 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 0 0 0 5.50 6.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5. 01 TENTATIVE TO PROVIDER 5. 02 0 0 0 5. 01 5. 03 Provider to Program 5. 50 TENTATIVE TO PROGRAM 6. 00 0 0 5. 55 5. 51 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 8. 707, 476 Number Number Number Number Number Number Number Number No Contractor Number Number Number Number No Contractor Number Number							
appropriate	4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 551, 153		0	4.00
TO BE COMPLÉTED BY CONTRACTOR							
S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider			T				
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVIDER							
5.02 0	E 01		T				E 01
5.03 Provider to Program S.50 TENTATIVE TO PROGRAM O O S.50 5.51 O O O S.51 5.52 O O O S.51 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines S.50-5.98 6.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM O O S.50 6.01 SETTLEMENT TO PROGRAM O O O O 7.00 Total Medicare program liability (see instructions) S.707,476 O T.00 Contractor NPR Date (Mo/Day/Yr)		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	5.05	Provider to Program		0		U	5.05
5.51	5 50			0		0	5 50
5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr)		TENTITIVE TO TROOM WI		_			
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 156,323 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 8,707,476 Contractor NPR Date (Mo/Day/Yr)							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 8,707,476 Contractor NPR Date (Mo/Day/Yr)		Subtotal (sum of lines 5 01-5 49 minus sum of lines		_			
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 8,707,476 Contractor NPR Date (Mo/Day/Yr)	0. , ,			Ŭ			0. ,,
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 156, 323 0 6.01 0 6.02 8, 707, 476 0 7.00 Contractor NPR Date (Mo/Day/Yr)	6.00						6. 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 8,707,476 Contractor NPR Date (Mo/Day/Yr)							
7.00 Total Medicare program liability (see instructions) 8,707,476 Contractor Number (Mo/Day/Yr)	6. 01			156, 323		0	6. 01
Contractor NPR Date Number (Mo/Day/Yr)	6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
Number (Mo/Day/Yr)	7.00	Total Medicare program liability (see instructions)		8, 707 <u>,</u> 476		o	7. 00
					Contractor	NPR Date	
0 1.00 2.00							
		T	()	1. 00	2. 00	
8.00 Name of Contractor 8.00	8.00	Name of Contractor					8. 00

Health Financial Systems	Lafayette Regional Rehab	ilitation Hospit	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3042	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part III Date/Time Prepared: 4/30/2024 11:02 am
		T		4/30/2024 11.02 alli

				4/30/2024 11:0	02 am_
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8, 563, 185	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0302	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			486, 389	3. 00
4.00	Outlier Payments				4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)				5. 00
5. 01	Cap increases for the unweighted intern and resident FTE coun- program or hospital closure, that would not be counted withou			0. 00	5. 01
6.00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 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 po	eriod of a "new	0. 00	7. 00
8. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth po	eriod of a "new	0.00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0. 00	9. 00
10.00	Average Daily Census (see instructions)	,		25. 841096	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	11. 00
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			9, 086, 877	13.00
14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	ŕ			15. 00
16.00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	16. 00
17.00	Subtotal (see instructions)	ŕ		9, 086, 877	17. 00
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			9, 086, 877	19. 00
20.00	Deducti bl es			106, 980	20. 00
21. 00	Subtotal (line 19 minus line 20)			8, 979, 897	21. 00
22. 00	Coi nsurance			115, 200	22. 00
23.00	Subtotal (line 21 minus line 22)			8, 864, 697	23. 00
24.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		31, 512	
	Adjusted reimbursable bad debts (see instructions)	, (20, 483	
	ON Allowable bad debts for dual eligible beneficiaries (see instructions)			24, 371	26. 00
	Subtotal (sum of lines 23 and 25)	,		8, 885, 180	27. 00
	Direct graduate medical education payments (from Wkst. E-4, Ii	ne 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			0	29. 00
	Outlier payments reconciliation			0	30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	31. 50
31. 98	Recovery of accelerated depreciation.	,		0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32.00	Total amount payable to the provider (see instructions)			8, 885, 180	32. 00
32. 01	Sequestration adjustment (see instructions)			177, 704	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33. 00	Interim payments			8, 551, 153	
34. 00	Tentative settlement (for contractor use only)			0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02	2. 33. and 34)		156, 323	
36. 00	Protested amounts (nonallowable cost report items) in accordan	•	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			37, 303	
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	
53.00	Time Value of Money (see instructions)			0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND THE COVID-19 PHE)				
99. 00	Teaching Adjustment Factor for the cost reporting period immed		ry 29, 2020.	0. 000000	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	l	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

Peri od: Worksheet G
From 01/01/2023
To 12/31/2023 Date/Ti me Prepared: 4/30/2024 11:02 am

——————————————————————————————————————					4/30/2024 11:	02 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	LOUDDENT AGOSTO	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	58, 792	0	0	0	1.00
2. 00	Temporary investments	36, 792	0	_		
3.00	Notes recei vabl e	0	ő	0	l o	3. 00
4.00	Accounts receivable	2, 872, 843	0	0	0	4. 00
5.00	Other recei vable	85, 547	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	104, 740	1	0	0	6. 00
7.00	Inventory	111, 950	0	0	0	
8. 00 9. 00	Prepaid expenses Other current assets	338, 991 8, 388	0	0	0	
10.00	Due from other funds	0, 300	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	3, 581, 251		0	•	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12. 00
13. 00	Land improvements	0	0	0		13. 00
14. 00	Accumulated depreciation	0	0	0	1	14. 00
15. 00	Buildings	10, 703, 267	1	0	1	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-1, 365, 873	0	0	0	16. 00 17. 00
18. 00	Accumulated depreciation		0	0	0	18.00
19. 00	Fi xed equipment	24, 112	_	0	0	19.00
20. 00	Accumul ated depreciation	-20, 704		0	Ō	20.00
21.00	Automobiles and trucks	61, 836	0	0	0	21. 00
22. 00	Accumulated depreciation	-49, 449	1	0	0	22. 00
23. 00	Major movable equipment	2, 696, 916		0	0	23. 00
24. 00	Accumulated depreciation	-2, 344, 162	i	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00 26. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation		0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e		Ö	0		29. 00
30.00	Total fixed assets (sum of lines 12-29)	9, 705, 943	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0	0	0	-	1
32. 00	Deposits on Leases	0	0	0	-	32.00
33.00	Due from owners/officers	220 472 502	0	0	0	33. 00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	229, 473, 503 229, 473, 503	1	0	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	242, 760, 697	1	Ū		36.00
00.00	CURRENT LIABILITIES	2 12 7 00 7 0 7 7				00.00
37.00	Accounts payable	379, 668	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	537, 857	0	0	_	38. 00
39. 00	Payroll taxes payable	82, 191	0	0	0	1
40. 00	Notes and loans payable (short term)	0	0	0	0	40.00
41. 00 42. 00	Deferred income Accel erated payments	0	U	0	0	41. 00 42. 00
43.00	Due to other funds		0	0	0	43.00
44. 00	Other current liabilities	245, 087, 599	Ö	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	246, 087, 315		0	l .	1
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	-	
47. 00	Notes payable	176, 995		0	-	
48. 00	Unsecured Loans Other Long term Liabilities	0 454 201	0	0		1
49. 00 50. 00	Total long term liabilities (sum of lines 46 thru 49)	9, 656, 301 9, 833, 296		-		49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	255, 920, 611	1			51.00
	CAPITAL ACCOUNTS		_			
52.00	General fund balance	-13, 159, 914				52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0	•	54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0 0	57. 00 58. 00
56.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	-13, 159, 914	0	n	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	242, 760, 697	1	0	0	
	59)					

16.00

17.00

18.00

19.00

0

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-3042 Peri od: Worksheet G-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 4/30/2024 11:02 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period -14, 052, 212 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 892, 298 2.00 3.00 Total (sum of line 1 and line 2) -13, 159, 914 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) -13, 159, 914 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 -13, 159, 914 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 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

 Heal th Financial
 Systems
 Lafayette
 Regional
 Rehabilitation
 Hospit

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

			To 12/31/2023	Date/Time Pre 4/30/2024 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	OZ GIII
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES		<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	9, 875, 25	0	9, 875, 250	1. 00
2.00	SUBPROVIDER - IPF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY		0	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)	9, 875, 25	0	9, 875, 250	10. 00
	Intensive Care Type Inpatient Hospital Services				
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	0	16. 00
17.00	11-15)	0.075.05	.0	0 075 250	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	9, 875, 25		9, 875, 250	17. 00
18.00	Ancillary services	11, 405, 55	1, 460, 805	12, 866, 355	18.00
19.00	Outpatient services		0 0	0	19.00
20. 00 21. 00	RURAL HEALTH CLINIC			0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0	21.00
23. 00	AMBULANCE SERVICES			0	23. 00
24. 00	CMHC			U	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPICE				26. 00
27. 00	OTHER (SPECIFY)			0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	21, 280, 80	1, 460, 805	22, 741, 605	28. 00
20.00	G-3, line 1)	21, 200, 00	1, 400, 003	22, 741, 003	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		15, 052, 833		29. 00
30. 00	ADD (SPECIFY)		0		30.00
31. 00			o		31. 00
32. 00			o		32. 00
33. 00			0		33. 00
34.00			0		34.00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39.00			0		39. 00
40.00			0		40. 00
41.00			0		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)(transfer	r	15, 052, 833		43.00
	to Wkst. G-3, line 4)				

STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-3042	Peri od:	Worksheet G-3	
			From 01/01/2023		
			To 12/31/2023	Date/Time Prep	
			1	4/30/2024 11: 0)2 am
				1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			22, 741, 605	1.00	
2.00	D Less contractual allowances and discounts on patients' accounts			6, 950, 285	2.00
3.00	Net patient revenues (line 1 minus line 2)			15, 791, 320	3.00
4.00	· · · · · · · · · · · · · · · · · · ·			15, 052, 833	4.00
5.00 Net income from service to patients (line 3 minus line 4)			738, 487	5.00	
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			-1, 767	7.00
8.00	Revenues from telephone and other miscellaneous communication services			ol	8. 00

5.00	Net income from service to patients (line 3 minus line 4)	738, 487	5. 00
	OTHER I NCOME		
6.00	Contri buti ons, donati ons, bequests, etc	0	6. 00
7.00	Income from investments	-1, 767	7. 00
8.00	Revenues from telephone and other miscellaneous communication services	0	8. 00
9.00	Revenue from television and radio service	0	9. 00
10. 00	Purchase di scounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
12.00	Parking lot receipts	0	12.00
13. 00	Revenue from laundry and linen service	0	13.00
14. 00	Revenue from meals sold to employees and guests	6, 690	14.00
15. 00	Revenue from rental of living quarters	0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	120	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen	0	20. 00
21. 00	Rental of vending machines	0	21. 00
22. 00	Rental of hospital space	0	22. 00
23. 00	Governmental appropriations	0	23. 00
24. 00	MISC INC, TRANSPORT, EMP PHYS SVCS	148, 768	24.00
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25. 00	Total other income (sum of lines 6-24)	153, 811	25. 00
26. 00	Total (line 5 plus line 25)	892, 298	26. 00
27. 00	OTHER EXPENSES (SPECIFY)	0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)	0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)	892, 298	29. 00