

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0463
Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 5/16/2022 3:00 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: _____	Time: _____
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Contractor No. _____	7. <input type="checkbox"/> First Cost Report for this Provider CCN
	5. Date Received: _____	8. <input type="checkbox"/> Last Cost Report for this Provider CCN	9. NPR Date: _____
		10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened	11. Contractor Vendor Code <u>4</u>
		12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR
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 FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT NEW MILFORD (315306) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1	1	2	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			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	110,120	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	110,120	0	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete and review the information collection is estimated 202 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.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315306		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/16/2022 3:00 pm			
1.00		2.00		3.00					
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:									
1.00	Street: 800 RIVER ROAD	PO Box:						1.00	
2.00	City: NEW MILFORD	State: NJ	Zip Code: 07646					2.00	
3.00	County: BERGEN	CBSA Code: 35614	Urban/Rural: U					3.00	
3.01		CBSA Code:						3.01	
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)				
		1.00	2.00	3.00	V	XVIII	XIX		
SNF and SNF-Based Component Identification:									
4.00	SNF	CARE ONE AT NEW MILFORD	315306	05/01/2003	N	P	N	4.00	
5.00	Nursing Facility							5.00	
6.00	ICF/IID							6.00	
7.00	SNF-Based HHA							7.00	
8.00	SNF-Based RHC							8.00	
9.00	SNF-Based FOHC							9.00	
10.00	SNF-Based CMHC							10.00	
11.00	SNF-Based OLTC							11.00	
12.00	SNF-Based HOSPICE							12.00	
13.00	SNF-Based CORF							13.00	
				From:	To:				
				1.00	2.00				
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2021	12/31/2021		14.00		
15.00	Type of Control (See Instructions)			4				15.00	
				Y/N					
				1.00					
Type of Freestanding Skilled Nursing Facility									
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					Y		16.00	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		17.00	
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y		18.00	
Miscellaneous Cost Reporting Information									
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.									
20.00	Straight Line							20.00	
21.00	Declining Balance							21.00	
22.00	Sum of the Year's Digits							22.00	
23.00	Sum of line 20 through 22							23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.							24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00	
				Part A	Part B	Other			
				1.00	2.00	3.00			
29.00	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.					N	N	N	29.00
30.00	Skilled Nursing Facility								30.00
31.00	Nursing Facility								31.00
32.00	ICF/IID								32.00
33.00	SNF-Based HHA					N	N		33.00
34.00	SNF-Based RHC						N		34.00
35.00	SNF-Based FOHC							N	35.00
36.00	SNF-Based CMHC								36.00
36.00	SNF-Based OLTC								36.00
				Y/N					
				1.00		2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					N		37.00	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					Y		38.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.					1		39.00	
				Premiums	Paid Losses	Self Insurance			
				1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:					51,267	0	0	41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/16/2022 3:00 pm
				Y/N
				1.00
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N 42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			Y 43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			HB0206 44.00
	1.00	2.00	3.00	
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.				
45.00	Name: HEALTHBRIDGE	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 12001	45.00
46.00	Street: 173 NORTH BRIDGE PLAZA	PO Box:		46.00
47.00	City: FORT LEE	State: NJ	Zip Code: 07024	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/16/2022 3:00 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/01/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y		9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		N		10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N		11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N		12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	03/31/2022	Y	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX REIMBURSEMENT QUESTIONNAIRE

Provider No. : 315306

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/16/2022 3:00 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHARLES	REED	19.00
20.00	Enter the employer/company name of the cost report preparer.	EXECUCARE ASSOCIATES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(609)738-3200	CRWASSC@NETSCAPE.NET	21.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX REIMBURSEMENT QUESTIONNAIRE

Provider No. : 315306

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/16/2022 3:00 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/31/2022	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE-PRESIDENT	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

VOLUNTARY CONTACT INFORMATION

Provider No. : 315306

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

Worksheet S-2
Part V
Date/Time Prepared:
5/16/2022 3:00 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	CHARLES J	1.00
2.00	Last Name	REED	2.00
3.00	Title	VICE - PRESIDENT	3.00
4.00	Employer	EXECUCARE ASSOCIATES	4.00
5.00	Phone Number	6097383200	5.00
6.00	E-mail Address	CRWASSC@NETSCAPE.NET	6.00
7.00	Department		7.00
8.00	Mailing Address 1	PO BOX 299	8.00
9.00	Mailing Address 2		9.00
10.00	City	CREAMRIDGE	10.00
11.00	State		NJ 11.00
12.00	Zip	08514	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	FRAN	13.00
14.00	Last Name	PETRI CONE	14.00
15.00	Title	VICE PRESIDENT OF FINANCIAL OPERATIO	15.00
16.00	Employer	CARE ONE	16.00
17.00	Phone Number	9788312123	17.00
18.00	E-mail Address	FPETRI CONE@CARE-ONE.COM	18.00
19.00	Department		19.00
20.00	Mailing Address 1	173 BRIDGE PLAZA NORTH	20.00
21.00	Mailing Address 2		21.00
22.00	City	FORT LEE	22.00
23.00	State		NJ 23.00
24.00	Zip	07024	24.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX STATISTICAL DATA

Provider No. : 315306

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/16/2022 3:00 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	236	86,140	0	6,809	50,546	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of Lines 1-7)	236	86,140	0	6,809	50,546	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	8,266	65,621	0	114	105	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of Lines 1-7)	8,266	65,621	0	114	105	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	73	292	0.00	59.73	481.39	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of Lines 1-7)	73	292	0.00	59.73	481.39	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
1.00	SKILLED NURSING FACILITY	224.73	0	103	37	146	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of Lines 1-7)	224.73	0	103	37	146	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	286	201.76	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of Lines 1-7)	286	201.76	0.00	8.00		

Provider No. : 315306

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

Worksheet S-3
Part II
Date/Time Prepared:
5/16/2022 3:00 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	11,058,526	0	11,058,526	419,663.00	26.35 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	11,058,526	0	11,058,526	419,663.00	26.35 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	11,058,526	0	11,058,526	419,663.00	26.35 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1,631,509	0	1,631,509	27,312.00	59.74 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	2,705,529	0	2,705,529		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	2,705,529	0	2,705,529		

Provider No. : 315306

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

Worksheet S-3
Part III
Date/Time Prepared:
5/16/2022 3:00 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	555,300	0	555,300	14,122.00	2.00
3.00	Plant Operation, Maintenance & Repairs	148,820	0	148,820	7,650.00	3.00
4.00	Laundry & Linen Service	106,751	0	106,751	6,654.00	4.00
5.00	Housekeeping	624,565	0	624,565	37,728.00	5.00
6.00	Dietary	884,207	0	884,207	44,791.00	6.00
7.00	Nursing Administration	1,131,719	0	1,131,719	43,358.00	7.00
8.00	Central Services and Supply	37,174	0	37,174	2,313.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	30,300	0	30,300	1,924.00	10.00
11.00	Social Service	149,261	0	149,261	4,874.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	500,648	0	500,648	29,713.00	13.00
14.00	Total (sum lines 1 thru 13)	4,168,745	0	4,168,745	193,127.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/16/2022 3:00 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		54,245	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		1,336,475	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		2,619	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		298,905	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		852,345	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		156,584	20.00
OTHER				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		4,356	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		2,705,529	24.00
			Amount Reported	
			1.00	
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315306

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

Worksheet S-3
Part V
Date/Time Prepared:
5/16/2022 3:00 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	1,267,376	330,632	1,598,008	32,474.00	49.21	1.00
2.00	Licensed Practical Nurses (LPNs)	1,963,273	512,177	2,475,450	61,242.00	40.42	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,315,361	604,029	2,919,390	99,782.00	29.26	3.00
4.00	Total Nursing (sum of lines 1 through 3)	5,546,010	1,446,838	6,992,848	193,498.00	36.14	4.00
5.00	Physical Therapists	651,399	169,936	821,335	15,732.00	52.21	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	562,756	146,811	709,567	14,353.00	49.44	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	129,616	33,814	163,430	2,953.00	55.34	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	297,161		297,161	3,715.00	79.99	14.00
15.00	Licensed Practical Nurses (LPNs)	538,575		538,575	7,693.00	70.01	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	792,400		792,400	15,848.00	50.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1,628,136		1,628,136	27,256.00	59.73	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	1,600		1,600	21.00	76.19	24.00
25.00	Respiratory Therapists	1,773		1,773	35.00	50.66	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315306

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

Worksheet S-7

Date/Time Prepared:
5/16/2022 3:00 pm

		Group	Days	
		1. 00	2. 00	
1. 00		RUX		1. 00
2. 00		RUL		2. 00
3. 00		RVX		3. 00
4. 00		RVL		4. 00
5. 00		RHX		5. 00
6. 00		RHL		6. 00
7. 00		RMX		7. 00
8. 00		RML		8. 00
9. 00		RLX		9. 00
10. 00		RUC		10. 00
11. 00		RUB		11. 00
12. 00		RUA		12. 00
13. 00		RVC		13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21. 00		RMA		21. 00
22. 00		RLB		22. 00
23. 00		RLA		23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00		HD1		30. 00
31. 00		HC2		31. 00
32. 00		HC1		32. 00
33. 00		HB2		33. 00
34. 00		HB1		34. 00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00		LD2		37. 00
38. 00		LD1		38. 00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41. 00		LB2		41. 00
42. 00		LB1		42. 00
43. 00		CE2		43. 00
44. 00		CE1		44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50. 00		CB1		50. 00
51. 00		CA2		51. 00
52. 00		CA1		52. 00
53. 00		SE3		53. 00
54. 00		SE2		54. 00
55. 00		SE1		55. 00
56. 00		SSC		56. 00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		IB2		59. 00
60. 00		IB1		60. 00
61. 00		IA2		61. 00
62. 00		IA1		62. 00
63. 00		BB2		63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66. 00
67. 00		PE2		67. 00
68. 00		PE1		68. 00
69. 00		PD2		69. 00
70. 00		PD1		70. 00
71. 00		PC2		71. 00
72. 00		PC1		72. 00
73. 00		PB2		73. 00
74. 00		PB1		74. 00
75. 00		PA2		75. 00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315306

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

Worksheet S-7

Date/Time Prepared:
5/16/2022 3:00 pm

		Group	Days	
76.00		1.00	2.00	
99.00		PA1		76.00
100.00	TOTAL	AAA		99.00
				100.00
		Expenses	Percentage	Y/N
		1.00	2.00	3.00
<p>A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)</p>				
101.00	Staffing			101.00
102.00	Recruitment			102.00
103.00	Retention of employees			103.00
104.00	Training			104.00
105.00	OTHER (SPECIFY)			105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)			106.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet A	Date/Time Prepared: 5/16/2022 3:00 pm		
Cost Center	Description	Salaries 1.00	Other 2.00	Total (col. 1 + col. 2) 3.00	Reclassified Increase/Decrease (Fr Wkst A-6) 4.00	Reclassified Trial Balance (col. 3 + col. 4) 5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		3,031,566	3,031,566	0	3,031,566	1.00
2.00	00200		144,468	144,468	0	144,468	2.00
3.00	00300	0	2,884,937	2,884,937	0	2,884,937	3.00
4.00	00400	555,300	4,422,768	4,978,068	0	4,978,068	4.00
5.00	00500	148,820	913,511	1,062,331	0	1,062,331	5.00
6.00	00600	106,751	145,800	252,551	0	252,551	6.00
7.00	00700	624,565	122,995	747,560	0	747,560	7.00
8.00	00800	884,207	592,342	1,476,549	0	1,476,549	8.00
9.00	00900	1,131,719	116,214	1,247,933	0	1,247,933	9.00
10.00	01000	37,174	284,839	322,013	-588	321,425	10.00
11.00	01100	0	44,619	44,619	0	44,619	11.00
12.00	01200	30,300	0	30,300	0	30,300	12.00
13.00	01300	149,261	0	149,261	0	149,261	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	500,648	29,181	529,829	0	529,829	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,546,010	1,681,764	7,227,774	0	7,227,774	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	37,925	37,925	0	37,925	40.00
41.00	04100	0	572,601	572,601	0	572,601	41.00
42.00	04200	0	140,322	140,322	0	140,322	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	651,399	60,426	711,825	0	711,825	44.00
45.00	04500	562,756	0	562,756	0	562,756	45.00
46.00	04600	129,616	1,600	131,216	0	131,216	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	588	588	48.00
49.00	04900	0	232,371	232,371	0	232,371	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	1,450	1,450	0	1,450	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	33,632	33,632	0	33,632	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	0	0	0	0	0	80.00
81.00	08100	0	0	0	0	0	81.00
82.00	08200	0	0	0	0	0	82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		11,058,526	15,495,331	26,553,857	0	26,553,857	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	2,688	2,688	0	2,688	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
100.00		11,058,526	15,498,019	26,556,545	0	26,556,545	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315306

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

Worksheet A
Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-1,417,837	1,613,729	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	144,468	2.00
3.00	00300	EMPLOYEE BENEFITS	0	2,884,937	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-1,073,836	3,904,232	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	1,062,331	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	-1,744	250,807	6.00
7.00	00700	HOUSEKEEPING	0	747,560	7.00
8.00	00800	DIETARY	0	1,476,549	8.00
9.00	00900	NURSING ADMINISTRATION	-4,097	1,243,836	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	321,425	10.00
11.00	01100	PHARMACY	-3,570	41,049	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	30,300	12.00
13.00	01300	SOCIAL SERVICE	0	149,261	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	529,829	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-15,547	7,212,227	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	37,925	40.00
41.00	04100	LABORATORY	0	572,601	41.00
42.00	04200	INTRAVENOUS THERAPY	-11,226	129,096	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	711,825	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	562,756	45.00
46.00	04600	SPEECH PATHOLOGY	0	131,216	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	588	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	-18,589	213,782	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	1,450	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	52.02
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
63.00	06300	DIALYSIS	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	33,632	71.00
73.00	07300	CMHC	0	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	-2,546,446	24,007,411	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	2,688	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	95.00
100.00		TOTAL	-2,546,446	24,010,099	100.00

RECLASSIFICATIONS

Provider No. : 315306

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

Worksheet A-6

Date/Time Prepared:
5/16/2022 3:00 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
1.00	(1) A - RECLASS MED SUPP CHARGED					
		MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00	0	588	1.00
100.00	TOTALS	Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		0	588	100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 (2) Transfer to Worksheet A, col. 5, line as appropriate.

Provider No. : 315306

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

Worksheet A-6

Date/Time Prepared:
5/16/2022 3:00 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
	(1) A - RECLASS MED SUPP CHARGED	6.00	7.00	8.00	9.00	
1.00		CENTRAL SERVICES & SUPPLY	10.00	0	588	1.00
100.00	TOTALS			0	588	100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, col. 5, line as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315306

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

Worksheet A-7

Date/Time Prepared:
5/16/2022 3:00 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	0	0	0	0	0	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	0	0	0	0	0	6.00
7.00 Subtotal (sum of lines 1-6)	0	0	0	0	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	0	0	0	0	0	9.00

Description	Ending Balance	Fully Depreciated Assets	
	6.00	7.00	

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0				1.00
2.00 Land Improvements	0	0				2.00
3.00 Buildings and Fixtures	0	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	0	0				6.00
7.00 Subtotal (sum of lines 1-6)	0	0				7.00
8.00 Reconciling Items	0	0				8.00
9.00 Total (line 7 minus line 8)	0	0				9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315306

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

Worksheet A-8

Date/Time Prepared:
5/16/2022 3:00 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line No.
			1.00	2.00	3.00
1.00 Investment income on restricted funds (chapter 2)	B	-6,243	CAP REL COSTS - BLDGS & FIXTURES	1.00	1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	2.00
3.00 Refunds and rebates of expenses (chapter 8)		0		0.00	3.00
4.00 Rental of provider space by suppliers (chapter 8)		0		0.00	4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	5.00
6.00 Television and radio service (chapter 21)		0		0.00	6.00
7.00 Parking lot (chapter 21)		0		0.00	7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00 Home office cost (chapter 21)		0		0.00	9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00	11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-1,365,409			12.00
13.00 Laundry and linen service	B	-1,744	LAUNDRY & LINEN SERVICE	6.00	13.00
14.00 Revenue - Employee meals		0		0.00	14.00
15.00 Cost of meals - Guests		0		0.00	15.00
16.00 Sale of medical supplies to other than patients		0		0.00	16.00
17.00 Sale of drugs to other than patients		0		0.00	17.00
18.00 Sale of medical records and abstracts		0		0.00	18.00
19.00 Vending machines		0		0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF	82.00	22.00
23.00 Depreciation--buildings and fixtures			CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00 Depreciation--movable equipment			CAP REL COSTS - MOVABLE EQUIPMENT	2.00	24.00
25.00 MISC EXP	A	-1,185	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01 RESIDENT REPLACEMENT ITEMS	A	-87	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02 MARKETING	A	-121,675	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03 SHOWS AND CONFERENCES	A	-1,399	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04 SPONSORSHIPS	A	-296	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05 BAD DEBTS	A	-660,002	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06 OTHER MEDICAL SERVICES	A	-15,547	SKILLED NURSING FACILITY	30.00	25.06
25.07 RESIDENT PERSONAL ITEMS	B	-426	ADMINISTRATIVE & GENERAL	4.00	25.07
25.08 OTHER REV	B	-372,433	ADMINISTRATIVE & GENERAL	4.00	25.08
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-2,546,446			100.00

(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.

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

Provider No. : 315306

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

Worksheet A-8-1
Parts 1-11
Date/Time Prepared:
5/16/2022 3:00 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00
2.00		4.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR	2.00
3.00		4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	3.00
4.00		9.00	NURSING ADMINISTRATION	PHARMACY CONSULTANT	4.00
5.00		10.00	CENTRAL SERVICES & SUPPLY	WOUND CARE	5.00
6.00		11.00	PHARMACY	N/L DRUGS	6.00
7.00		11.00	PHARMACY	PHAR SUPP	7.00
8.00		42.00	INTRAVENOUS THERAPY	IV	8.00
9.00		49.00	DRUGS CHARGED TO PATIENTS	LEGEND DRUGS OTHER	9.00
9.01		49.00	DRUGS CHARGED TO PATIENTS	LEGEND DRUGS M CARE	9.01
9.02		49.00	DRUGS CHARGED TO PATIENTS	LEGEND DRUGS CARE A	9.02
9.03		0.00			9.03
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.				10.00
		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
		4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1,207,459	2,619,053	-1,411,594	1.00
2.00		0	645	-645	2.00
3.00		1,296,183	1,211,871	84,312	3.00
4.00		47,117	51,214	-4,097	4.00
5.00		22,424	22,424	0	5.00
6.00		39,696	43,148	-3,452	6.00
7.00		1,353	1,471	-118	7.00
8.00		129,096	140,322	-11,226	8.00
9.00		43,636	47,430	-3,794	9.00
9.01		61,218	66,541	-5,323	9.01
9.02		108,928	118,400	-9,472	9.02
9.03		0	0	0	9.03
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	2,957,110	4,322,519	-1,365,409	10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/16/2022 3:00 pm
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Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	A	THCI OF NJ	100.00	1.00
2.00	A	THCI OF NJ	100.00	2.00
3.00	A	THCI OF NJ	100.00	3.00
4.00	A	CARE ONE	100.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Related Organization(s) and/or Home Office		
	Name	Percentage of Ownership	Type of Business
	4.00	5.00	6.00

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

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

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

1.00	800 RIVER ROAD LLC	100.00	REALTY	1.00
2.00	HEALTHBRI DGE MANAGEMENT	100.00	HOME OFFICE	2.00
3.00	PARTNERS PHARMACY	68.10	PHARMACY	3.00
4.00	TOTAL CARE LLC	100.00	WOUND CARE	4.00
5.00		0.00		5.00
6.00		0.00		6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:	0.00		100.00

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

COST ALLOCATION - GENERAL SERVICE COSTS		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/16/2022 3:00 pm
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,613,729	1,613,729			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	144,468		144,468		2.00
3.00 00300	EMPLOYEE BENEFITS	2,884,937	25,608	2,293	2,912,838	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,904,232	40,215	3,600	146,267	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,062,331	56,417	5,051	39,199	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	250,807	36,651	3,281	28,118	6.00
7.00 00700	HOUSEKEEPING	747,560	17,072	1,528	164,512	7.00
8.00 00800	DIETARY	1,476,549	172,565	15,449	232,902	8.00
9.00 00900	NURSING ADMINISTRATION	1,243,836	108,855	9,745	298,097	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	321,425	11,354	1,016	9,792	10.00
11.00 01100	PHARMACY	41,049	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	30,300	5,180	464	7,981	12.00
13.00 01300	SOCIAL SERVICE	149,261	82,128	7,352	39,316	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	529,829	0	0	131,872	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	7,212,227	1,023,208	91,603	1,460,830	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	37,925	0	0	0	40.00
41.00 04100	LABORATORY	572,601	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	129,096	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	711,825	22,397	2,005	171,580	44.00
45.00 04500	OCCUPATIONAL THERAPY	562,756	6,796	608	148,231	45.00
46.00 04600	SPEECH PATHOLOGY	131,216	1,326	119	34,141	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	588	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	213,782	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	1,450	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	33,632	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	24,007,411	1,609,772	144,114	2,912,838	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	2,688	3,957	354	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	24,010,099	1,613,729	144,468	2,912,838	100.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider No. : 315306		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part I Date/Time Prepared: 5/16/2022 3:00 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	4,094,314				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	239,090	1,402,088			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	65,551	34,454	418,862		6.00	
7.00	00700	HOUSEKEEPING	191,328	16,049	0	1,138,049	7.00	
8.00	00800	DIETARY	390,083	162,221	0	136,592	2,586,361	8.00
9.00	00900	NURSING ADMINISTRATION	341,374	102,331	0	86,163	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	70,635	10,673	0	8,987	0	10.00
11.00	01100	PHARMACY	8,439	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	9,030	4,869	0	4,100	0	12.00
13.00	01300	SOCIAL SERVICE	57,163	77,206	0	65,008	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	136,033	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	2,012,206	961,876	418,862	809,910	2,586,361	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	7,797	0	0	0	0	40.00
41.00	04100	LABORATORY	117,716	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	26,540	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	186,628	21,054	0	17,728	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	147,688	6,388	0	5,379	0	45.00
46.00	04600	SPEECH PATHOLOGY	34,291	1,247	0	1,050	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	121	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	43,950	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	298	0	0	0	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FQHC	0	0	0	0	0	62.00
63.00	06300	DIALYSIS	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	6,914	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	4,092,875	1,398,368	418,862	1,134,917	2,586,361	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	1,439	3,720	0	3,132	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	4,094,314	1,402,088	418,862	1,138,049	2,586,361	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315306

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

Worksheet B
Part I
Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	2,190,401					9.00
10.00	01000	0	433,882				10.00
11.00	01100	0	0	49,488			11.00
12.00	01200	0	0	0	61,924		12.00
13.00	01300	0	0	0	0	477,434	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,190,401	433,882	49,488	61,924	477,434	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		2,190,401	433,882	49,488	61,924	477,434	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		2,190,401	433,882	49,488	61,924	477,434	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315306

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

Worksheet B
Part I
Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	797,734			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	797,734	20,587,946	0	20,587,946
31.00 03100	NURSING FACILITY	0	0	0	0	0
32.00 03200	ICF/IID	0	0	0	0	0
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	45,722	0	45,722
41.00 04100	LABORATORY	0	0	690,317	0	690,317
42.00 04200	INTRAVENOUS THERAPY	0	0	155,636	0	155,636
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00 04400	PHYSICAL THERAPY	0	0	1,133,217	0	1,133,217
45.00 04500	OCCUPATIONAL THERAPY	0	0	877,846	0	877,846
46.00 04600	SPEECH PATHOLOGY	0	0	203,390	0	203,390
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	709	0	709
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	257,732	0	257,732
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00 05100	SUPPORT SURFACES	0	0	1,748	0	1,748
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0
52.02 05202	MEDICAL SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00 06200	FOHC	0	0	0	0	0
63.00 06300	DIALYSIS	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00 07100	AMBULANCE	0	0	40,546	0	40,546
73.00 07300	CMHC	0	0	0	0	0
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0
89.00	SUBTOTALS (sum of lines 1-84)	0	797,734	23,994,809	0	23,994,809
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00 09100	BARBER AND BEAUTY SHOP	0	0	15,290	0	15,290
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00 09300	NONPAID WORKERS	0	0	0	0	0
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0
98.00	Cross Foot Adjustments	0	0	0	0	0
99.00	Negative Cost Centers	0	0	0	0	0
100.00	TOTAL	0	797,734	24,010,099	0	24,010,099

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315306

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

Worksheet B
Part II
Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	25,608	2,293	27,901	27,901 3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	40,215	3,600	43,815	1,401 4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	56,417	5,051	61,468	375 5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	36,651	3,281	39,932	269 6.00
7.00 00700	HOUSEKEEPING	0	17,072	1,528	18,600	1,576 7.00
8.00 00800	DIETARY	0	172,565	15,449	188,014	2,231 8.00
9.00 00900	NURSING ADMINISTRATION	0	108,855	9,745	118,600	2,855 9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	11,354	1,016	12,370	94 10.00
11.00 01100	PHARMACY	0	0	0	0	0 11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	5,180	464	5,644	76 12.00
13.00 01300	SOCIAL SERVICE	0	82,128	7,352	89,480	377 13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0 14.00
15.00 01500	ACTIVITIES	0	0	0	0	1,263 15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	1,023,208	91,603	1,114,811	13,994 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	0 40.00
41.00 04100	LABORATORY	0	0	0	0	0 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0 43.00
44.00 04400	PHYSICAL THERAPY	0	22,397	2,005	24,402	1,643 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	6,796	608	7,404	1,420 45.00
46.00 04600	SPEECH PATHOLOGY	0	1,326	119	1,445	327 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0 52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0 52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	0 52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC	0	0	0	0	0 62.00
63.00 06300	DIALYSIS	0	0	0	0	0 63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	0 74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0 84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0 84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	1,609,772	144,114	1,753,886	27,901 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	3,957	354	4,311	0 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0 95.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers		0	0	0	0 99.00
100.00	TOTAL	0	1,613,729	144,468	1,758,197	27,901 100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315306		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/16/2022 3:00 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	45,216				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	2,640	64,483			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	724	1,585	42,510		6.00	
7.00	00700	HOUSEKEEPING	2,113	738	0	23,027	7.00	
8.00	00800	DIETARY	4,307	7,461	0	2,764	204,777	8.00
9.00	00900	NURSING ADMINISTRATION	3,769	4,706	0	1,743	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	780	491	0	182	0	10.00
11.00	01100	PHARMACY	93	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	100	224	0	83	0	12.00
13.00	01300	SOCIAL SERVICE	631	3,551	0	1,315	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	1,502	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	22,226	44,237	42,510	16,388	204,777	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	86	0	0	0	0	40.00
41.00	04100	LABORATORY	1,300	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	293	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	2,061	968	0	359	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	1,631	294	0	109	0	45.00
46.00	04600	SPEECH PATHOLOGY	379	57	0	21	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	1	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	485	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	3	0	0	0	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FQHC	0	0	0	0	0	62.00
63.00	06300	DIALYSIS	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	76	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	45,200	64,312	42,510	22,964	204,777	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	16	171	0	63	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	45,216	64,483	42,510	23,027	204,777	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/16/2022 3:00 pm
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	131,673					9.00
10.00	01000	0	13,917				10.00
11.00	01100	0	0	93			11.00
12.00	01200	0	0	0	6,127		12.00
13.00	01300	0	0	0	0	95,354	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	131,673	13,917	93	6,127	95,354	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		131,673	13,917	93	6,127	95,354	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		131,673	13,917	93	6,127	95,354	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315306

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

Worksheet B
Part II
Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE ACTIVITIES	Subtotal	Post Step-Down Adjustments	Total	
		14.00 15.00 16.00 17.00 18.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	2,765			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	2,765	1,708,872	0	1,708,872 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	86	0	86 40.00
41.00 04100	LABORATORY	0	0	1,300	0	1,300 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	293	0	293 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0 43.00
44.00 04400	PHYSICAL THERAPY	0	0	29,433	0	29,433 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	10,858	0	10,858 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	2,229	0	2,229 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	1 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	485	0	485 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	3	0	3 51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0 52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0 52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	0 52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC					62.00
63.00 06300	DIALYSIS	0	0	0	0	0 63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	76	0	76 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	0 74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0 84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0 84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	2,765	1,753,636	0	1,753,636 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	4,561	0	4,561 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0 95.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	2,765	1,758,197	0	1,758,197 100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

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

Worksheet B-1

Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)				
	1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	77,888				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		77,888			2.00
3.00 00300	EMPLOYEE BENEFITS	1,236	1,236	11,058,526		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,941	1,941	555,300	-4,094,314	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	2,723	2,723	148,820	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,769	1,769	106,751	0	6.00
7.00 00700	HOUSEKEEPING	824	824	624,565	0	7.00
8.00 00800	DIETARY	8,329	8,329	884,207	0	8.00
9.00 00900	NURSING ADMINISTRATION	5,254	5,254	1,131,719	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	548	548	37,174	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	250	250	30,300	0	12.00
13.00 01300	SOCIAL SERVICE	3,964	3,964	149,261	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	0	0	500,648	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	49,386	49,386	5,546,010	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	1,081	1,081	651,399	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	328	328	562,756	0	45.00
46.00 04600	SPEECH PATHOLOGY	64	64	129,616	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	77,697	77,697	11,058,526	-4,094,314	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	191	191	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1,613,729	144,468	2,912,838		102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	20.718583	1.854817	0.263402		103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			27,901		104.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

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

Worksheet B-1

Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)				
	1.00	2.00				
105.00 Unit cost multiplier (Wkst. B, Part II)			0.002523	4A	0.002270	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

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

Worksheet B-1

Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500	71,988					5.00
6.00	00600	1,769	65,621				6.00
7.00	00700	824	0	69,395			7.00
8.00	00800	8,329	0	8,329	196,863		8.00
9.00	00900	5,254	0	5,254	0	65,621	9.00
10.00	01000	548	0	548	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	250	0	250	0	0	12.00
13.00	01300	3,964	0	3,964	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	49,386	65,621	49,386	196,863	65,621	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,081	0	1,081	0	0	44.00
45.00	04500	328	0	328	0	0	45.00
46.00	04600	64	0	64	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		71,797	65,621	69,204	196,863	65,621	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	191	0	191	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00		1,402,088	418,862	1,138,049	2,586,361	2,190,401	102.00
103.00		19.476691	6.383048	16.399582	13.137873	33.379574	103.00
104.00		64,483	42,510	23,027	204,777	131,673	104.00
105.00		0.895747	0.647811	0.331825	1.040201	2.006568	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

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

Worksheet B-1

Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	65,621					10.00
11.00	01100	0	65,621				11.00
12.00	01200	0	0	65,621			12.00
13.00	01300	0	0	0	65,621		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	65,621	65,621	65,621	65,621	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		65,621	65,621	65,621	65,621	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	433,882	49,488	61,924	477,434	0	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	6.611938	0.754149	0.943661	7.275628	0.000000	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	13,917	93	6,127	95,354	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.212081	0.001417	0.093370	1.453102	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

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

Worksheet B-1
Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description		OTHER GENERAL SERVICE		
		ACTIVITIES (PATIENT DAYS)		
		15.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500	ACTIVITIES	65,621	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	65,621	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF/IID	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	40.00
41.00	04100	LABORATORY	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100	SUPPORT SURFACES	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	52.01
52.02	05202	MEDICAL SERVICES	0	52.02
OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FOHC	0	62.00
63.00	06300	DIALYSIS	0	63.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
73.00	07300	CMHC	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	74.00
SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	65,621	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	95.00
98.00		Cross Foot Adjustments		98.00
99.00		Negative Cost Centers		99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	797,734	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	12.156688	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	2,765	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.042136	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315306

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

Worksheet C

Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description			Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 di vi ded by col. 2)	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	45,722	94,812	0.482239	40.00
41.00	04100	LABORATORY	690,317	1,431,503	0.482232	41.00
42.00	04200	INTRAVENOUS THERAPY	155,636	350,805	0.443654	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	1,133,217	2,890,380	0.392065	44.00
45.00	04500	OCCUPATIONAL THERAPY	877,846	2,839,043	0.309205	45.00
46.00	04600	SPEECH PATHOLOGY	203,390	727,434	0.279599	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	709	1,471	0.481985	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	257,732	580,928	0.443656	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	1,748	3,625	0.482207	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0.000000	52.01
52.02	05202	MEDICAL SERVICES	0	0	0.000000	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FQHC				62.00
63.00	06300	DIALYSIS	0	0	0.000000	63.00
71.00	07100	AMBULANCE	40,546	84,080	0.482231	71.00
100.00		Total	3,406,863	9,004,081		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/16/2022 3:00 pm
		Title XVIII (1)	Skilled Nursing Facility	PPS

Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost				
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)			
		2.00	3.00	4.00	5.00			
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0.482239	26,375	0	12,719	0	40.00
41.00	04100	LABORATORY	0.482232	22,741	0	10,966	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.443654	139	0	62	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.392065	983,960	0	385,776	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.309205	922,503	0	285,243	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.279599	352,818	0	98,648	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481985	1,471	0	709	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0.443656	95,978	0	42,581	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0.482207	329	0	159	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0.000000	0	0	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0.000000	0	0	0	0	52.01
52.02	05202	MEDICAL SERVICES	0.000000	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0.000000	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC						61.00
62.00	06200	FOHC						62.00
63.00	06300	DIALYSIS	0.000000	0	0	0	0	63.00
71.00	07100	AMBULANCE (2)	0.482231		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		2,406,314	0	836,863	0	100.00

(1) For title V and XIX use columns 1, 2, and 4 only.

(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Prepared: 5/16/2022 3:00 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	0.443656	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	0	3.00

Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)
		1.00	2.00	3.00	4.00	5.00

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	45,722	0	0.000000	12,719	0	40.00
41.00	04100	LABORATORY	690,317	0	0.000000	10,966	0	41.00
42.00	04200	INTRAVENOUS THERAPY	155,636	0	0.000000	62	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1,133,217	0	0.000000	385,776	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	877,846	0	0.000000	285,243	0	45.00
46.00	04600	SPEECH PATHOLOGY	203,390	0	0.000000	98,648	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	709	0	0.000000	709	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	257,732	0	0.000000	42,581	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	1,748	0	0.000000	159	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0.000000	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	0.000000	0	0	52.02
100.00		Total (Sum of lines 40 - 52)	3,366,317	0		836,863	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-III Date/Time Prepared: 5/16/2022 3:00 pm
	Title XVIII	Skilled Nursing Facility	PPS

	1.00	
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PART I CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1.00	Inpatient days including private room days	65,621	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	6,809	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	20,587,946	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	25,997,712	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.791914	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	20,587,946	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	313.74	16.00
17.00	Program routine service cost (Line 3 times line 16)	2,136,256	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	2,136,256	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	1,708,872	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	26.04	21.00
22.00	Program capital related cost (Line 3 times line 21)	177,306	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,958,950	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,958,950	25.00
26.00	Enter the per diem limitation (1)		26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

	1.00	
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PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days	65,621	1.00
2.00	Program inpatient days (see instructions)	6,809	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.103763	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-III Date/Time Prepared: 5/16/2022 3:00 pm
	Title XIX	Skilled Nursing Facility	

	1.00	
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PART I CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1.00	Inpatient days including private room days	65,621	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	50,546	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	20,587,946	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	25,997,712	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.791914	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	20,587,946	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	313.74	16.00
17.00	Program routine service cost (Line 3 times line 16)	15,858,302	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	15,858,302	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	1,708,872	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	26.04	21.00
22.00	Program capital related cost (Line 3 times line 21)	1,316,218	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	14,542,084	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	14,542,084	25.00
26.00	Enter the per diem limitation (1)	0.00	26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	0	27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)	15,858,302	28.00

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

	1.00	
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PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days	65,621	1.00
2.00	Program inpatient days (see instructions)	50,546	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.770272	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVII I		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Prepared: 5/16/2022 3:00 pm
		Title XVII I	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		5,967,782	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		5,967,782	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinurance		916,803	5.00
6.00	Allowable bad debts (From your records)		490,909	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		281,857	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		319,091	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		5,370,070	11.00
12.00	Interim payments (See instructions)		5,259,950	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		0	14.75
14.99	Sequestration amount (see instructions)		0	14.99
15.00	Balance due provider/program (see Instructions)		110,120	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCI LLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVII I ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Prepared: 5/16/2022 3:00 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		5,050,979 246,715		0 2.00
3.00	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)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/17/2021	37,744		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		-37,744		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		5,259,950		0 4.00
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)				5.00
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0 5.01
5.02			0		0 5.02
5.03			0		0 5.03
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0 5.50
5.51			0		0 5.51
5.52			0		0 5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0 5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	PROGRAM TO PROVIDER		110,120		0 6.01
6.02	PROVIDER TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		5,370,070		0 7.00
		Contractor Name		Contractor Number	
		1.00		2.00	
8.00	Name of Contractor			8.00	

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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

Provider No. : 315306

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

Worksheet G

Date/Time Prepared:
5/16/2022 3:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	14,383	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,103,512	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-150,852	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	29,955	0	0	0	8.00
9.00	Other current assets	89,122	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	5,086,120	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	11,000	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	11,000	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	5,097,120	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,834,878	0	0	0	35.00
36.00	Salaries, wages, and fees payable	0	0	0	0	36.00
37.00	Payroll taxes payable	235,796	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	89,122	0	0	0	41.00
42.00	Other current liabilities	460,380	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2,620,176	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	964,575	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	964,575	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	3,584,751	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,512,369	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	1,512,369	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	5,097,120	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315306

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

Worksheet G-1

Date/Time Prepared:
5/16/2022 3:00 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,383,616			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		128,744				2.00
3.00	Total (sum of line 1 and line 2)		1,512,360			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDING	9			0	0	5.00
6.00		0			0	0	6.00
7.00		0			0	0	7.00
8.00		0			0	0	8.00
9.00		0			0	0	9.00
10.00	Total additions (sum of line 5 - 9)		9			0	10.00
11.00	Subtotal (line 3 plus line 10)		1,512,369			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		1,512,369			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDING		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 5 - 9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)						12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315306

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

Worksheet G-2
Parts I-11
Date/Time Prepared:
5/16/2022 3:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	25,997,712		25,997,712	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	25,997,712		25,997,712	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	9,004,081	0	9,004,081	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	35,001,793	0	35,001,793	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			26,556,545	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			26,556,545	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider No. : 315306	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/16/2022 3:00 pm
			1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)		35,001,793	1.00
2.00	Less: contractual allowances and discounts on patients accounts		12,672,813	2.00
3.00	Net patient revenues (Line 1 minus line 2)		22,328,980	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)		26,556,545	4.00
5.00	Net income from service to patients (Line 3 minus 4)		-4,227,565	5.00
Other income:				
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		6,243	7.00
8.00	Revenues from communications (Telephone and Internet service)		0	8.00
9.00	Revenue from television and radio service		0	9.00
10.00	Purchase discounts		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		1,744	13.00
14.00	Revenue from meals sold to employees and guests		0	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		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen		0	20.00
21.00	Rental of vending machines		0	21.00
22.00	Rental of skilled nursing space		0	22.00
23.00	Governmental appropriations		0	23.00
24.00	BARBER AND BEAUTY		2,511	24.00
24.01	RESIDENT PERSONAL ITEMS		426	24.01
24.02	OTHER REVENUE		4,328,165	24.02
24.50	COVID-19 PHE Funding		17,220	24.50
25.00	Total other income (Sum of lines 6 - 24)		4,356,309	25.00
26.00	Total (Line 5 plus line 25)		128,744	26.00
27.00	Other expenses (specify)		0	27.00
28.00			0	28.00
29.00			0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)		0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)		128,744	31.00