

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: 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 5/23/2022 6:28 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 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.	Date: 5/23/2022	Time: 6:28 pm
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 5. Date Received: _____	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 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 CHESHIRE HOME, INC. ( 315383 ) 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	George Zeitler	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	George Zeitler		2
3	Signatory Title	EXECUTIVE DIRECTOR		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00 SKILLED NURSING FACILITY	0	0	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0		0	4.00
5.00 SNF - BASED RHC I	0			0	5.00
6.00 SNF - BASED FQHC I	0			0	6.00
7.00 SNF - BASED CMHC I	0			0	7.00
100.00 TOTAL	0	0	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. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 6:28 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 9 RIDGEDALE AVE	PO Box:				1.00		
2.00	City: FLORHAM PARK	State: NJ	Zip Code: 07932-2329			2.00		
3.00	County: MORRIS	CBSA Code: 35084	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
					V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	CHESHIRE HOME, INC.	315383	12/01/1997	N	P	O	
5.00	Nursing Facility							
6.00	ICF/IID							
7.00	SNF-Based HHA							
8.00	SNF-Based RHC							
9.00	SNF-Based FQHC							
10.00	SNF-Based CMHC							
11.00	SNF-Based OLTC							
12.00	SNF-Based HOSPICE							
13.00	SNF-Based CORF							
				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)				2		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?					N		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.					N		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					221,220		20.00
21.00	Declining Balance					0		21.00
22.00	Sum of the Year's Digits					0		22.00
23.00	Sum of line 20 through 22					221,220		23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		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
30.00	Skilled Nursing Facility							
31.00	Nursing Facility							
32.00	ICF/IID					N	N	N
33.00	SNF-Based HHA							
34.00	SNF-Based RHC							
35.00	SNF-Based FQHC							
36.00	SNF-Based CMHC							
36.00	SNF-Based OLTC							
				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)					Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N		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.							39.00
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:					0	0	0

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 6:28 pm
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		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?	N	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.		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:	Contractor's Name:	Contractor's Number:
46.00	Street:	PO Box:	
47.00	City:	State:	Zip Code:

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/23/2022 6:28 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)	N			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		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.			N	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.)	N		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.	Y		N	18.00

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

Provider No. : 315383

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/23/2022 6:28 pm

		1.00	2.00	
<b>Cost Report Preparer Contact Information</b>				
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.	VARIOUS	VARIOUS	19.00
20.00	Enter the employer/company name of the cost report preparer.	HUBCO HEALTH CARE GROUP		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-730-1980	COSTREPORTS@HUBCO.NET	21.00

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

Provider No. : 315383

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
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		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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.)	06/28/2021	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	
<b>Cost Report Preparer Contact Information</b>			
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.	STAFF	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

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

Provider No. : 315383

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

Worksheet S-3  
 Part I  
 Date/Time Prepared:  
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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	35	12,775	0	0	8,622	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	35	12,775	0	0	8,622	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	3,272	11,894	0	0	31	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST	0	0				4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	3,272	11,894	0	0	31	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	7	38	0.00	0.00	278.13	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	7	38	0.00	0.00	278.13	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	313.00	0	0	29	8	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	313.00	0	0	29	8	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	37	82.24	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID				3.00		
4.00	HOME HEALTH AGENCY COST		0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC		0.00	0.00	6.00		
7.00	HOSPICE				7.00		
8.00	Total (Sum of lines 1-7)	37	82.24	0.00	8.00		

Provider No. : 315383

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
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	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	
<b>PART II - DIRECT SALARIES</b>						
<b>SALARIES</b>						
1.00	Total salaries (See Instructions)	5,345,528	0	5,345,528	171,053.00	31.25 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)	5,345,528	0	5,345,528	171,053.00	31.25 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)	5,345,528	0	5,345,528	171,053.00	31.25 13.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	314,545	0	314,545	6,087.00	51.67 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
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	1,445,918	0	1,445,918		
18.00	Wage-related costs other (See Part IV)	15,279	0	15,279		
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)	1,461,197	0	1,461,197		



Provider No. : 315383

Period:  
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Worksheet S-3  
Part III  
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	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	
<b>PART III - OVERHEAD COST - DIRECT SALARIES</b>						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	977,308	0	977,308	26,424.00	2.00
3.00	Plant Operation, Maintenance & Repairs	103,070	0	103,070	3,136.00	3.00
4.00	Laundry & Linen Service	0	0	0.00	0.00	4.00
5.00	Housekeeping	0	0	0.00	0.00	5.00
6.00	Dietary	354,909	0	354,909	15,712.00	6.00
7.00	Nursing Administration	306,112	0	306,112	5,819.00	7.00
8.00	Central Services and Supply	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	6,232	0	6,232	189.00	10.00
11.00	Social Service	111,605	0	111,605	3,766.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	261,460	0	261,460	8,181.00	13.00
14.00	Total (sum lines 1 thru 13)	2,120,696	0	2,120,696	63,227.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2022 6:28 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	129,650	3.00
4.00	Prior Year Pension Service Cost	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	695,794	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	23,478	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,573	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)	31,667	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	132,174	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	389,947	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	31,635	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1,445,918	24.00
		Amount Reported	
		1.00	
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS	15,279	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315383

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/23/2022 6:28 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	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	437,592	119,616	557,208	10,097.00	55.19	1.00
2.00	Licensed Practical Nurses (LPNs)	1,083,515	296,178	1,379,693	31,185.00	44.24	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,342,234	366,899	1,709,133	58,224.00	29.35	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,863,341	782,693	3,646,034	99,506.00	36.64	4.00
5.00	Physical Therapists	245,951	67,231	313,182	5,608.00	55.85	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	115,540	31,583	147,123	2,712.00	54.25	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	0	0	0	0.00	0.00	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
<b>Contract Labor</b>							
<b>Nursing Occupations</b>							
14.00	Registered Nurses (RNs)	3,684		3,684	57.00	64.63	14.00
15.00	Licensed Practical Nurses (LPNs)	225,977		225,977	4,062.00	55.63	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	56,664		56,664	1,789.00	31.67	16.00
17.00	Total Nursing (sum of lines 14 through 16)	286,325		286,325	5,908.00	48.46	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	28,220		28,220	179.00	157.65	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315383

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

Worksheet S-7  
Date/Time Prepared:  
5/23/2022 6:28 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. : 315383

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

Worksheet S-7

Date/Time Prepared:  
5/23/2022 6:28 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
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)				
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. : 315383

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

Worksheet A  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		309,725	309,725	0	309,725	1.00
2.00	00200		34,971	34,971	0	34,971	2.00
3.00	00300	0	1,461,197	1,461,197	0	1,461,197	3.00
4.00	00400	977,308	1,103,224	2,080,532	0	2,080,532	4.00
5.00	00500	103,070	486,554	589,624	0	589,624	5.00
6.00	00600	0	4,156	4,156	0	4,156	6.00
7.00	00700	0	237,296	237,296	0	237,296	7.00
8.00	00800	354,909	239,040	593,949	0	593,949	8.00
9.00	00900	306,112	12,000	318,112	0	318,112	9.00
10.00	01000	0	276,191	276,191	0	276,191	10.00
11.00	01100	0	18,340	18,340	0	18,340	11.00
12.00	01200	6,232	0	6,232	0	6,232	12.00
13.00	01300	111,605	0	111,605	0	111,605	13.00
15.00	01500	261,460	20,962	282,422	0	282,422	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,863,341	317,657	3,180,998	0	3,180,998	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	475	475	0	475	42.00
43.00	04300	0	48,275	48,275	0	48,275	43.00
44.00	04400	245,951	4,029	249,980	0	249,980	44.00
45.00	04500	115,540	0	115,540	0	115,540	45.00
46.00	04600	0	28,220	28,220	0	28,220	46.00
48.00	04800	0	10,047	10,047	0	10,047	48.00
49.00	04900	0	42,967	42,967	0	42,967	49.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
62.00	06200						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
<b>SPECIAL PURPOSE COST CENTERS</b>							
89.00		5,345,528	4,655,326	10,000,854	0	10,000,854	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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
100.00		5,345,528	4,655,326	10,000,854	0	10,000,854	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315383

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

Worksheet A  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-25,762	283,963	1.00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT	-34,971	0	2.00
3.00	00300	EMPLOYEE BENEFITS	-16,351	1,444,846	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-673,694	1,406,838	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	-19,582	570,042	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	4,156	6.00
7.00	00700	HOUSEKEEPING	-3,675	233,621	7.00
8.00	00800	DIETARY	-536	593,413	8.00
9.00	00900	NURSING ADMINISTRATION	0	318,112	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	276,191	10.00
11.00	01100	PHARMACY	0	18,340	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	6,232	12.00
13.00	01300	SOCIAL SERVICE	0	111,605	13.00
15.00	01500	PATIENT ACTIVITIES	-1,949	280,473	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	-4,320	3,176,678	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	0	0	40.00
41.00	04100	LABORATORY	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	475	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	48,275	43.00
44.00	04400	PHYSICAL THERAPY	0	249,980	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	115,540	45.00
46.00	04600	SPEECH PATHOLOGY	0	28,220	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,047	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	42,967	49.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
62.00	06200	FOHC			62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
89.00		SUBTOTALS (sum of lines 1-84)	-780,840	9,220,014	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	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	-780,840	9,220,014	100.00

Provider No. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet A-6 Date/Time Prepared: 5/23/2022 6:28 pm
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		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)				0	0 100.00

(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. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet A-6 Date/Time Prepared: 5/23/2022 6:28 pm
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		Decreases			
		Cost Center	Line #	Salary	Non Salary
		6.00	7.00	8.00	9.00
100.00	TOTALS			0	0
					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. : 315383

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

Worksheet A-7

Date/Time Prepared:  
5/23/2022 6:28 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	218,915	0	0	0	1.00
2.00	Land Improvements	118,860	0	0	0	2.00
3.00	Buildings and Fixtures	4,015,390	0	0	0	3.00
4.00	Building Improvements	1,627,980	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	2,172,149	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	8,153,294	0	0	0	7.00
8.00	Reconciling Items	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	8,153,294	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	218,915	0			1.00
2.00	Land Improvements	118,860	0			2.00
3.00	Buildings and Fixtures	4,015,390	0			3.00
4.00	Building Improvements	1,627,980	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	2,172,149	0			6.00
7.00	Subtotal (sum of lines 1-6)	8,153,294	0			7.00
8.00	Reconciling Items	0	0			8.00
9.00	Total (line 7 minus line 8)	8,153,294	0			9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315383

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

Worksheet A-8

Date/Time Prepared:  
5/23/2022 6:28 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	4.00
1.00 Investment income on restricted funds (chapter 2)	B	-25,762		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	0				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals	B	-536		DIETARY	8.00	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	B	-410		ADMINISTRATIVE & GENERAL	4.00	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)		0		*** Cost Center Deleted ***	82.00	22.00
23.00 Depreciation--buildings and fixtures		0		CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00 Depreciation--movable equipment		0		CAP REL COSTS - MOVEABLE EQUIPMENT	2.00	24.00
25.00		0			0.00	25.00
25.01 MISCELLANEOUS	B	-21,514		ADMINISTRATIVE & GENERAL	4.00	25.01
25.02 GROUP HOME EXPENSES	A	-34,971		CAP REL COSTS - MOVEABLE EQUIPMENT	2.00	25.02
25.03 GROUP HOME EXPENSES	A	-16,351		EMPLOYEE BENEFITS	3.00	25.03
25.04 GROUP HOME EXPENSES	A	-71,678		ADMINISTRATIVE & GENERAL	4.00	25.04
25.05 GROUP HOME EXPENSES	A	-19,582		PLANT OPERATION, MAINT. & REPAIRS	5.00	25.05
25.06 GROUP HOME EXPENSES	A	-3,675		HOUSEKEEPING	7.00	25.06
25.07 GROUP HOME EXPENSES	A	-1,949		PATIENT ACTIVITIES	15.00	25.07
25.08 ATTENDING PHYSICIANS	A	-12,000		ADMINISTRATIVE & GENERAL	4.00	25.08
25.09 CONTRIBUTIONS	A	-600		ADMINISTRATIVE & GENERAL	4.00	25.09
25.10 NON REIMBURSABLE	A	-1,430		ADMINISTRATIVE & GENERAL	4.00	25.10
25.11 PHYSICIAN ST	B	-4,320		SKILLED NURSING FACILITY	30.00	25.11
25.12 FUNDRAISING	A	-259,467		ADMINISTRATIVE & GENERAL	4.00	25.12
25.13 BAD DEBT	A	-306,595		ADMINISTRATIVE & GENERAL	4.00	25.13
25.14		0			0.00	25.14
25.15		0			0.00	25.15
25.16		0			0.00	25.16
25.17		0			0.00	25.17
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-780,840				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.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315383

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVEABLE EQUIPMENT			
	0	1.00	2.00	3.00	3A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	283,963	283,963			1.00
2.00 00200	CAP REL COSTS - MOVEABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	1,444,846	0	0	1,444,846	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,406,838	37,650	0	264,158	1,708,646 4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	570,042	5,719	0	27,859	603,620 5.00
6.00 00600	LAUNDRY & LINEN SERVICE	4,156	2,288	0	0	6,444 6.00
7.00 00700	HOUSEKEEPING	233,621	1,048	0	0	234,669 7.00
8.00 00800	DIETARY	593,413	35,744	0	95,929	725,086 8.00
9.00 00900	NURSING ADMINISTRATION	318,112	0	0	82,739	400,851 9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	276,191	0	0	0	276,191 10.00
11.00 01100	PHARMACY	18,340	1,072	0	0	19,412 11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	6,232	0	0	1,684	7,916 12.00
13.00 01300	SOCIAL SERVICE	111,605	3,145	0	30,166	144,916 13.00
15.00 01500	PATIENT ACTIVITIES	280,473	38,163	0	70,670	389,306 15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	3,176,678	159,134	0	773,934	4,109,746 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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	475	0	0	0	475 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	48,275	0	0	0	48,275 43.00
44.00 04400	PHYSICAL THERAPY	249,980	0	0	66,478	316,458 44.00
45.00 04500	OCCUPATIONAL THERAPY	115,540	0	0	31,229	146,769 45.00
46.00 04600	SPEECH PATHOLOGY	28,220	0	0	0	28,220 46.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,047	0	0	0	10,047 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	42,967	0	0	0	42,967 49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
<b>SPECIAL PURPOSE COST CENTERS</b>						
89.00	SUBTOTALS (sum of lines 1-84)	9,220,014	283,963	0	1,444,846	9,220,014 89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	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	9,220,014	283,963	0	1,444,846	9,220,014 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315383

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2022 6:28 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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	1,708,646				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	137,308	740,928			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	1,466	7,045	14,955		6.00	
7.00	00700	HOUSEKEEPING	53,381	3,229	0	291,279	7.00	
8.00	00800	DIETARY	164,939	110,077	0	43,883	1,043,985	8.00
9.00	00900	NURSING ADMINISTRATION	91,184	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	62,827	0	0	0	0	10.00
11.00	01100	PHARMACY	4,416	3,302	0	1,316	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	1,801	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	32,965	9,687	0	3,862	0	13.00
15.00	01500	PATIENT ACTIVITIES	88,557	117,525	0	46,852	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	934,863	490,063	14,955	195,366	1,043,985	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
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	108	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	10,981	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	71,986	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	33,386	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	6,419	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,285	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	9,774	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
62.00	06200	FOHC						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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
<b>SPECIAL PURPOSE COST CENTERS</b>								
89.00		SUBTOTALS (sum of lines 1-84)	1,708,646	740,928	14,955	291,279	1,043,985	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	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	1,708,646	740,928	14,955	291,279	1,043,985	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315383

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2022 6:28 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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	492,035					9.00
10.00	01000	0	339,018				10.00
11.00	01100	0	0	28,446			11.00
12.00	01200	0	0	0	9,717		12.00
13.00	01300	0	0	0	0	191,430	13.00
15.00	01500	0	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	492,035	339,018	28,446	9,717	191,430	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
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
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
62.00	06200						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
<b>SPECIAL PURPOSE COST CENTERS</b>							
89.00		492,035	339,018	28,446	9,717	191,430	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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		492,035	339,018	28,446	9,717	191,430	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315383

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total		
	PATIENT ACTIVITIES					
	15.00					16.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES				1.00	
2.00 00200	CAP REL COSTS - MOVEABLE 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	
15.00 01500	PATIENT ACTIVITIES	642,240			15.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	642,240	8,491,864	0	8,491,864	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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	583	0	583	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	59,256	0	59,256	43.00
44.00 04400	PHYSICAL THERAPY	0	388,444	0	388,444	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	180,155	0	180,155	45.00
46.00 04600	SPEECH PATHOLOGY	0	34,639	0	34,639	46.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,332	0	12,332	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	52,741	0	52,741	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
<b>SPECIAL PURPOSE COST CENTERS</b>						
89.00	SUBTOTALS (sum of lines 1-84)	642,240	9,220,014	0	9,220,014	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	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	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	642,240	9,220,014	0	9,220,014	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315383

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVEABLE EQUIPMENT			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVEABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	37,650	0	37,650	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	5,719	0	5,719	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	2,288	0	2,288	6.00
7.00 00700	HOUSEKEEPING	0	1,048	0	1,048	7.00
8.00 00800	DIETARY	0	35,744	0	35,744	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	1,072	0	1,072	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	3,145	0	3,145	13.00
15.00 01500	PATIENT ACTIVITIES	0	38,163	0	38,163	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	0	159,134	0	159,134	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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	0	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
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
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
<b>SPECIAL PURPOSE COST CENTERS</b>						
89.00	SUBTOTALS (sum of lines 1-84)	0	283,963	0	283,963	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	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				0	98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	283,963	0	283,963	100.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315383

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2022 6:28 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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	37,650				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	3,025	8,744			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	32	83	2,403		6.00	
7.00	00700	HOUSEKEEPING	1,176	38	0	2,262	7.00	
8.00	00800	DIETARY	3,634	1,299	0	341	41,018	8.00
9.00	00900	NURSING ADMINISTRATION	2,009	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	1,384	0	0	0	0	10.00
11.00	01100	PHARMACY	97	39	0	10	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	40	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	726	114	0	30	0	13.00
15.00	01500	PATIENT ACTIVITIES	1,951	1,387	0	364	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	20,604	5,784	2,403	1,517	41,018	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
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	2	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	242	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1,586	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	736	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	141	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	50	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	215	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
62.00	06200	FOHC						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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
<b>SPECIAL PURPOSE COST CENTERS</b>								
89.00		SUBTOTALS (sum of lines 1-84)	37,650	8,744	2,403	2,262	41,018	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	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	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	37,650	8,744	2,403	2,262	41,018	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315383

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	2,009					9.00
10.00	01000	0	1,384				10.00
11.00	01100	0	0	1,218			11.00
12.00	01200	0	0	0	40		12.00
13.00	01300	0	0	0	0	4,015	13.00
15.00	01500	0	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,009	1,384	1,218	40	4,015	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
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
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
62.00	06200						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
<b>SPECIAL PURPOSE COST CENTERS</b>							
89.00		2,009	1,384	1,218	40	4,015	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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	TOTAL	2,009	1,384	1,218	40	4,015	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315383

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total		
	PATIENT ACTIVITIES					
	15.00					16.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES				1.00	
2.00 00200	CAP REL COSTS - MOVEABLE 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	
15.00 01500	PATIENT ACTIVITIES	41,865			15.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	41,865	280,991	0	280,991	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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	2	0	2	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	242	0	242	43.00
44.00 04400	PHYSICAL THERAPY	0	1,586	0	1,586	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	736	0	736	45.00
46.00 04600	SPEECH PATHOLOGY	0	141	0	141	46.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	50	0	50	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	215	0	215	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
<b>SPECIAL PURPOSE COST CENTERS</b>						
89.00	SUBTOTALS (sum of lines 1-84)	41,865	283,963	0	283,963	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	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	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	41,865	283,963	0	283,963	100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315383

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

Worksheet B-1

Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVEABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	23,833					1.00
2.00 00200	CAP REL COSTS - MOVEABLE EQUIPMENT		0				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	5,345,528			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,160	0	977,308	-1,708,646	7,511,368	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	480	0	103,070	0	603,620	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	192	0	0	0	6,444	6.00
7.00 00700	HOUSEKEEPING	88	0	0	0	234,669	7.00
8.00 00800	DIETARY	3,000	0	354,909	0	725,086	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	306,112	0	400,851	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	276,191	10.00
11.00 01100	PHARMACY	90	0	0	0	19,412	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	6,232	0	7,916	12.00
13.00 01300	SOCIAL SERVICE	264	0	111,605	0	144,916	13.00
15.00 01500	PATIENT ACTIVITIES	3,203	0	261,460	0	389,306	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	SKILLED NURSING FACILITY	13,356	0	2,863,341	0	4,109,746	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	475	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	48,275	43.00
44.00 04400	PHYSICAL THERAPY	0	0	245,951	0	316,458	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	115,540	0	146,769	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	28,220	46.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,047	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	42,967	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
62.00 06200	FOHC						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
<b>SPECIAL PURPOSE COST CENTERS</b>							
89.00	SUBTOTALS (sum of lines 1-84)	23,833	0	5,345,528	-1,708,646	7,511,368	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	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						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	283,963	0	1,444,846		1,708,646	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	11.914698	0.000000	0.270291		0.227475	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		37,650	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.005012	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315383

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

Worksheet B-1

Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (PATIENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500	20,193					5.00
6.00	00600	192	11,894				6.00
7.00	00700	88	0	19,913			7.00
8.00	00800	3,000	0	3,000	11,894		8.00
9.00	00900	0	0	0	0	11,894	9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	90	0	90	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	264	0	264	0	0	13.00
15.00	01500	3,203	0	3,203	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	13,356	11,894	13,356	11,894	11,894	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
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
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
62.00	06200						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
<b>SPECIAL PURPOSE COST CENTERS</b>							
89.00		20,193	11,894	19,913	11,894	11,894	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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		740,928	14,955	291,279	1,043,985	492,035	102.00
103.00		36.692319	1.257357	14.627580	87.774088	41.368337	103.00
104.00		8,744	2,403	2,262	41,018	2,009	104.00
105.00		0.433021	0.202035	0.113594	3.448630	0.168909	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315383

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

Worksheet B-1

Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT DAYS)	
	10.00	11.00	12.00	13.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVEABLE 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	11,894				10.00
11.00 01100	PHARMACY	0	11,894			11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	11,894		12.00
13.00 01300	SOCIAL SERVICE	0	0	0	11,894	13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	0	11,894 15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	11,894	11,894	11,894	11,894	11,894 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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	0	0	0	0 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	0 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	0 46.00
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
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
<b>SPECIAL PURPOSE COST CENTERS</b>						
89.00	SUBTOTALS (sum of lines 1-84)	11,894	11,894	11,894	11,894	11,894 89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	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					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	339,018	28,446	9,717	191,430	642,240 102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	28.503279	2.391626	0.816967	16.094670	53.996973 103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	1,384	1,218	40	4,015	41,865 104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.116361	0.102405	0.003363	0.337565	3.519842 105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315383

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

Worksheet C  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description			Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
			1.00	2.00	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00	04000	RADIOLOGY	0	0	0.000000	40.00
41.00	04100	LABORATORY	0	11,680	0.000000	41.00
42.00	04200	INTRAVENOUS THERAPY	583	475	1.227368	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	59,256	4,827	12.275948	43.00
44.00	04400	PHYSICAL THERAPY	388,444	249,980	1.553900	44.00
45.00	04500	OCCUPATIONAL THERAPY	180,155	115,540	1.559244	45.00
46.00	04600	SPEECH PATHOLOGY	34,639	28,220	1.227463	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,332	10,047	1.227431	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	52,741	42,967	1.227477	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
62.00	06200	FOHC				62.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	728,150	463,736		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	Provider No. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/23/2022 6:28 pm
	Title XVIII (1)	Skilled Nursing Facility	PPS

Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3) 1.00	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	
<b>PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST</b>						
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00	04000 RADIOLOGY	0.000000	0	0	0	40.00
41.00	04100 LABORATORY	0.000000	0	0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	1.227368	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	12.275948	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	1.553900	0	0	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	1.559244	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	1.227463	0	0	0	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.227431	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.227477	0	0	0	49.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
62.00	06200 FOHC					62.00
71.00	07100 AMBULANCE (2)	0.000000		0		71.00
100.00	Total (Sum of lines 40 - 71)		0	0	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. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Prepared: 5/23/2022 6:28 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)	1.227477	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	0	0	0.000000	0 40.00
41.00	04100	LABORATORY	0	0	0.000000	0 41.00
42.00	04200	INTRAVENOUS THERAPY	583	0	0.000000	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	59,256	0	0.000000	0 43.00
44.00	04400	PHYSICAL THERAPY	388,444	0	0.000000	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	180,155	0	0.000000	0 45.00
46.00	04600	SPEECH PATHOLOGY	34,639	0	0.000000	0 46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,332	0	0.000000	0 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	52,741	0	0.000000	0 49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0 51.00
100.00		Total (Sum of lines 40 - 52)	728,150	0		0 100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIIII		Provider No. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Prepared: 5/23/2022 6:28 pm
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
<b>PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT</b>				
1.00	Inpatient PPS amount (See Instructions)		0	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)		0	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinurance		0	5.00
6.00	Allowable bad debts (From your records)		0	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		0	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)		0	11.00
12.00	Interim payments (See instructions)		0	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)		0	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
<b>PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIIII ONLY</b>				
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

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315383	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part II Date/Time Prepared: 5/23/2022 6:28 pm
		Title XIX	Skilled Nursing Facility	Cost
				1.00
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		0	4.00
5.00	Utilization review--physicians' compensation (from provider records)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)		0	6.00
7.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		0	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		0	10.00
<b>REASONABLE CHARGES</b>				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
<b>CUSTOMARY CHARGES</b>				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315383

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

Worksheet E-1

Date/Time Prepared:  
5/23/2022 6:28 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		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		0		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
<b>Program to Provider</b>						
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
<b>Provider to Program</b>						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		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)		0		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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		0		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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. : 315383

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

Worksheet G

Date/Time Prepared:  
5/23/2022 6:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>Assets</b>						
<b>CURRENT ASSETS</b>						
1.00	Cash on hand and in banks	2,140,968	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	2,301,153	0	0	0	4.00
5.00	Other receivables	694,739	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-1,382,605	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	52,124	0	0	0	8.00
9.00	Other current assets	2,519	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	<b>TOTAL CURRENT ASSETS (Sum of lines 1 - 10)</b>	<b>3,808,898</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	218,915	0	0	0	12.00
13.00	Land improvements	120,860	0	0	0	13.00
14.00	Less: Accumulated depreciation	-75,157	0	0	0	14.00
15.00	Buildings	4,015,390	0	0	0	15.00
16.00	Less Accumulated depreciation	-3,869,536	0	0	0	16.00
17.00	Leasehold improvements	1,667,072	0	0	0	17.00
18.00	Less: Accumulated Amortization	-1,092,596	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	358,263	0	0	0	21.00
22.00	Less: Accumulated depreciation	-346,484	0	0	0	22.00
23.00	Major movable equipment	2,362,508	0	0	0	23.00
24.00	Less: Accumulated depreciation	-1,809,850	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	43,296	0	0	0	27.00
28.00	<b>TOTAL FIXED ASSETS (Sum of lines 12 - 27)</b>	<b>1,592,681</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28.00</b>
<b>OTHER ASSETS</b>						
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	0	0	0	0	32.00
33.00	<b>TOTAL OTHER ASSETS (Sum of lines 29 - 32)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33.00</b>
34.00	<b>TOTAL ASSETS (Sum of lines 11, 28, and 33)</b>	<b>5,401,579</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34.00</b>
<b>Liabilities and Fund Balances</b>						
<b>CURRENT LIABILITIES</b>						
35.00	Accounts payable	197,598	0	0	0	35.00
36.00	Salaries, wages, and fees payable	483,863	0	0	0	36.00
37.00	Payroll taxes payable	0	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	221,653	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	<b>TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)</b>	<b>903,114</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43.00</b>
<b>LONG TERM LIABILITIES</b>						
44.00	Mortgage payable	106,624	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	0	0	0	0	48.00
49.00	PATIENT FUND LIABILITY	176,739	0	0	0	49.00
50.00	<b>TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)</b>	<b>283,363</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>TOTAL LIABILITIES (Sum of lines 43 and 50)</b>	<b>1,186,477</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	4,215,102	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	<b>TOTAL FUND BALANCES (Sum of lines 52 thru 58)</b>	<b>4,215,102</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>59.00</b>
60.00	<b>TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)</b>	<b>5,401,579</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315383

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

Worksheet G-1

Date/Time Prepared:  
5/23/2022 6:28 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		3,782,628		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		432,474			2.00
3.00	Total (sum of line 1 and line 2)		4,215,102		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		4,215,102		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		4,215,102		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			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. : 315383

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

Worksheet G-2  
Parts I-III  
Date/Time Prepared:  
5/23/2022 6:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Care Services</b>					
1.00	SKILLED NURSING FACILITY	8,100,241		8,100,241	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	97,278		97,278	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	8,197,519		8,197,519	5.00
<b>All Other Care Services</b>					
6.00	ANCILLARY SERVICES	134,652	0	134,652	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)	8,332,171	0	8,332,171	14.00
Cost Center Description			1.00	2.00	
<b>PART II - OPERATING EXPENSES</b>					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			10,000,854	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)			10,000,854	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315383

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

Worksheet G-3

Date/Time Prepared:  
5/23/2022 6:28 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	8,332,171	1.00
2.00	Less: contractual allowances and discounts on patients accounts	0	2.00
3.00	Net patient revenues (Line 1 minus line 2)	8,332,171	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	10,000,854	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,668,683	5.00
<b>Other income:</b>			
6.00	Contributions, donations, bequests, etc	484,175	6.00
7.00	Income from investments	25,764	7.00
8.00	Revenues from communications ( Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	520	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	0	13.00
14.00	Revenue from meals sold to employees and guests	536	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	410	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	1,262,255	23.00
24.00	Other miscellaneous revenue	327,492	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	2,101,152	25.00
26.00	Total (Line 5 plus line 25)	432,469	26.00
27.00	ROUNDING	-5	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	-5	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	432,474	31.00