

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: 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 5/23/2022 8:22 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report Date: 5/23/2022 Time: 8:22 pm 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 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 ST. JOSEPHS SENIORS HOME (315318) 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	Elizabeth Lopatka	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 Elizabeth Lopatka			2
3	Signatory Title ADMINISTRATOR			3
4	Date (Dated when report is electronic)			4

Cost Center Description	Title XVIII			Title XIX	
	Title V	Part A	Part B		
1.00	2.00	3.00	4.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	0	912	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		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	912	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. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 8:22 pm					
1.00		2.00		3.00					
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:									
1.00	Street: 1-3 ST. JOSEPHS TERRACE	PO Box:				1.00			
2.00	City: WOODBRI DGE	State: NJ	Zip Code: 07095			2.00			
3.00	County: MIDDLESEX	CBSA Code: 35154	Urban/Rural: U			3.00			
3.01		CBSA Code: 0				3.01			
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)				
		1.00	2.00	3.00	V	XVIII	XIX		
		4.00	5.00	6.00					
SNF and SNF-Based Component Identification:									
4.00	SNF	ST. JOSEPHS SENIORS HOME	315318	11/17/1992	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 FQHC							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)				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					243,578	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					243,578	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			
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.									
29.00	Skilled Nursing Facility					N	N	N	29.00
30.00	Nursing Facility								30.00
31.00	ICF/IID								31.00
32.00	SNF-Based HHA					N	N		32.00
33.00	SNF-Based RHC						N		33.00
34.00	SNF-Based FQHC						N		34.00
35.00	SNF-Based CMHC						N		35.00
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)					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		41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/23/2022 8:22 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?			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:	45.00
46.00	Street:	PO Box:		46.00
47.00	City:	State:	Zip Code:	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/23/2022 8:22 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.)	Y	05/18/2022	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. : 315318

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/23/2022 8:22 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.	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.	6097301980	COSTREPORTS@HUBCO.NET	21.00

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

Provider No. : 315318

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/23/2022 8:22 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.)	05/18/2022		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.	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. : 315318

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/23/2022 8:22 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	51	18,615	0	867	6,167	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	60	21,900				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	111	40,515	0	867	6,167	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	8,095	15,129	0	4	7	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	13,689	13,689				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	21,784	28,818	0	4	7	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	14	25	0.00	216.75	881.00	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	17	17				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	31	42	0.00	216.75	881.00	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	605.16	0	13	2	18	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	805.24				29	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	686.14	0	13	2	47	8.00
Component		Admissions		Full Time Equivalent			
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	33	41.71	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	29	31.97	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)	62	73.68	0.00		8.00	

Provider No. : 315318

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

Worksheet S-3
Part II
Date/Time Prepared:
5/23/2022 8:22 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)	3,110,809	0	3,110,809	157,405.20	19.76
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	3,110,809	0	3,110,809	157,405.20	19.76
7.00	Other Long Term Care	719,156	0	719,156	37,402.00	19.23
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00
9.00	CMHC	0	0	0	0.00	0.00
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	719,156	0	719,156	37,402.00	19.23
13.00	Total Adjusted Salaries (line 6 minus line 12)	2,391,653	0	2,391,653	120,003.20	19.93
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	210,469	0	210,469	1,669.25	126.09
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1,001,471	0	1,001,471		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	231,520	0	231,520		
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)	769,951	0	769,951		

SNF WAGE INDEX INFORMATION

Provider No. : 315318

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

Worksheet S-3
Part III
Date/Time Prepared:
5/23/2022 8:22 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	119,417	0	119,417	7,635.23	2.00
3.00	Plant Operation, Maintenance & Repairs	8,609	0	8,609	2,925.75	3.00
4.00	Laundry & Linen Service	204,899	0	204,899	10,727.50	4.00
5.00	Housekeeping	135,427	0	135,427	4,314.25	5.00
6.00	Dietary	417,475	0	417,475	22,448.25	6.00
7.00	Nursing Administration	0	0	0.00	0.00	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	0	0	0.00	0.00	10.00
11.00	Social Service	51,302	0	51,302	2,112.25	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	174,521	0	174,521	9,186.48	13.00
14.00	Total (sum lines 1 thru 13)	1,111,650	0	1,111,650	59,349.71	14.00

SNF WAGE RELATED COSTS		Provider No. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2022 8:22 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
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		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)	664,034		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)	0		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	77,395		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	260,042		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	0		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	0		23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1,001,471		24.00
				Amount Reported
				1.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315318

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

Worksheet S-3
Part V
Date/Time Prepared:
5/23/2022 8:22 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)	211,289	68,700	279,989	6,110.00	45.82	1.00
2.00	Licensed Practical Nurses (LPNs)	543,184	176,615	719,799	19,517.00	36.88	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,244,686	404,706	1,649,392	72,428.50	22.77	3.00
4.00	Total Nursing (sum of lines 1 through 3)	1,999,159	650,021	2,649,180	98,055.50	27.02	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	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
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	0		0	0.00	0.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	0		0	0.00	0.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	0		0	0.00	0.00	17.00
18.00	Physical Therapists	98,878		98,878	985.25	100.36	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	110,161		110,161	671.50	164.05	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	1,430		1,430	12.50	114.40	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. : 315318

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

Worksheet S-7

Date/Time Prepared:
5/23/2022 8:22 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. : 315318

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

Worksheet S-7

Date/Time Prepared:
5/23/2022 8:22 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. : 315318

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

Worksheet A
Date/Time Prepared:
5/23/2022 8:22 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		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		326,066	326,066	0	326,066	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,001,471	1,001,471	0	1,001,471	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	119,417	991,610	1,111,027	0	1,111,027	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	8,609	605,538	614,147	0	614,147	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	204,899	24,175	229,074	0	229,074	6.00
7.00	00700	HOUSEKEEPING	135,427	77,605	213,032	0	213,032	7.00
8.00	00800	DIETARY	417,475	439,866	857,341	0	857,341	8.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	110,016	110,016	0	110,016	10.00
11.00	01100	PHARMACY	0	19,215	19,215	0	19,215	11.00
13.00	01300	SOCIAL SERVICE	51,302	0	51,302	0	51,302	13.00
15.00	01500	PATIENT ACTIVITIES	174,521	107,734	282,255	0	282,255	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,280,003	402,395	1,682,398	0	1,682,398	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	719,156	179,390	898,546	0	898,546	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	2,887	2,887	0	2,887	40.00
41.00	04100	LABORATORY	0	29,189	29,189	0	29,189	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	98,878	98,878	0	98,878	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	110,161	110,161	0	110,161	45.00
46.00	04600	SPEECH PATHOLOGY	0	1,430	1,430	0	1,430	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,781	11,781	0	11,781	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	40,045	40,045	0	40,045	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
62.00	06200	FOHC						62.00
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
SPECIAL PURPOSE COST CENTERS								
89.00		SUBTOTALS (sum of lines 1-84)	3,110,809	4,579,452	7,690,261	0	7,690,261	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	1,638	1,638	0	1,638	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
100.00		TOTAL	3,110,809	4,581,090	7,691,899	0	7,691,899	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315318

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

Worksheet A
Date/Time Prepared:
5/23/2022 8:22 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	0	326,066	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,001,471	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-5,429	1,105,598	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	614,147	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	229,074	6.00
7.00	00700	HOUSEKEEPING	0	213,032	7.00
8.00	00800	DIETARY	0	857,341	8.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	110,016	10.00
11.00	01100	PHARMACY	0	19,215	11.00
13.00	01300	SOCIAL SERVICE	0	51,302	13.00
15.00	01500	PATIENT ACTIVITIES	0	282,255	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	1,682,398	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	898,546	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	2,887	40.00
41.00	04100	LABORATORY	0	29,189	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	98,878	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	110,161	45.00
46.00	04600	SPEECH PATHOLOGY	0	1,430	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,781	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	40,045	49.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
62.00	06200	FOHC			62.00
OTHER REIMBURSABLE COST CENTERS					
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
SPECIAL PURPOSE COST CENTERS					
89.00	SUBTOTALS (sum of lines 1-84)		-5,429	7,684,832	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	1,638	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	-5,429	7,686,470	100.00

Provider No. : 315318

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

Worksheet A-6

Date/Time Prepared:
5/23/2022 8:22 pm

		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Recl assi fi cations (Sum of col umns 4 and 5 must equal sum of col umns 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. : 315318

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

Worksheet A-6

Date/Time Prepared:
5/23/2022 8:22 pm

		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. : 315318

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

Worksheet A-7

Date/Time Prepared:
5/23/2022 8:22 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	91,241	0	0	0	0	2.00
3.00 Buildings and Fixtures	6,366,135	0	0	0	0	3.00
4.00 Building Improvements	1,156,512	0	0	0	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	390,709	0	0	0	0	6.00
7.00 Subtotal (sum of lines 1-6)	8,004,597	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)	8,004,597	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				
2.00 Land Improvements	91,241	0				
3.00 Buildings and Fixtures	6,366,135	0				
4.00 Building Improvements	1,156,512	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	390,709	0				
7.00 Subtotal (sum of lines 1-6)	8,004,597	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	8,004,597	0				

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)		0			0.00	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		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)		0		*** Cost Center Deleted ***	82.00	22.00
23.00 Depreciation--buildings and fixtures		0		OCAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00 Depreciation--movable equipment		0		*** Cost Center Deleted ***	2.00	24.00
25.00		0			0.00	25.00
25.01 ADVERTISING	A	-2,016		ADMINISTRATIVE & GENERAL	4.00	25.01
25.02 MISC INC NURSING	B	-3,413		ADMINISTRATIVE & GENERAL	4.00	25.02
25.03		0			0.00	25.03
25.04		0			0.00	25.04
25.05		0			0.00	25.05
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-5,429				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. : 315318

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2022 8:22 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	326,066	326,066			1.00
3.00 00300	EMPLOYEE BENEFITS	1,001,471	0	1,001,471		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,105,598	7,008	38,444	1,151,050	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	614,147	7,150	2,772	624,069	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	229,074	7,832	65,964	302,870	6.00
7.00 00700	HOUSEKEEPING	213,032	1,846	43,598	258,476	7.00
8.00 00800	DIETARY	857,341	29,856	134,399	1,021,596	8.00
10.00 01000	CENTRAL SERVICES & SUPPLY	110,016	0	0	110,016	10.00
11.00 01100	PHARMACY	19,215	0	0	19,215	11.00
13.00 01300	SOCIAL SERVICE	51,302	0	16,516	67,818	13.00
15.00 01500	PATIENT ACTIVITIES	282,255	18,790	56,184	357,229	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	1,682,398	130,186	412,074	2,224,658	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
33.00 03300	OTHER LONG TERM CARE	898,546	120,577	231,520	1,250,643	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	2,887	0	0	2,887	40.00
41.00 04100	LABORATORY	29,189	0	0	29,189	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	98,878	0	0	98,878	44.00
45.00 04500	OCCUPATIONAL THERAPY	110,161	0	0	110,161	45.00
46.00 04600	SPEECH PATHOLOGY	1,430	0	0	1,430	46.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,781	427	0	12,208	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	40,045	2,394	0	42,439	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
62.00 06200	FOHC					62.00
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
SPECIAL PURPOSE COST CENTERS						
89.00	SUBTOTALS (sum of lines 1-84)	7,684,832	326,066	1,001,471	7,684,832	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	1,638	0	0	1,638	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	7,686,470	326,066	1,001,471	7,686,470	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315318

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

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Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CENTRAL SERVICES & SUPPLY		
		5.00	6.00	7.00	8.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	733,983				5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	18,430	374,643			6.00	
7.00	00700	HOUSEKEEPING	4,344	0	308,344		7.00	
8.00	00800	DIETARY	70,258	0	30,460	1,302,243	8.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	129,393	10.00	
11.00	01100	PHARMACY	0	0	0	0	11.00	
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00	
15.00	01500	PATIENT ACTIVITIES	44,217	0	19,170	0	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	306,354	196,682	132,820	683,657	30.00	
31.00	03100	NURSING FACILITY	0	0	0	0	31.00	
33.00	03300	OTHER LONG TERM CARE	283,743	177,961	123,016	618,586	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	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	1,005	0	436	0	48.00	
49.00	04900	DRUGS CHARGED TO PATIENTS	5,632	0	2,442	0	49.00	
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00	
OUTPATIENT SERVICE COST CENTERS								
62.00	06200	FOHC					62.00	
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	
SPECIAL PURPOSE COST CENTERS								
89.00		SUBTOTALS (sum of lines 1-84)	733,983	374,643	308,344	1,302,243	129,393	89.00
NONREIMBURSABLE COST CENTERS								
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	733,983	374,643	308,344	1,302,243	129,393	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315318

Period:
From 01/01/2021
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Cost Center Description	PHARMACY	SOCIAL SERVICE	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments				
			PATIENT ACTIVITIES						
	11.00	13.00	15.00	16.00	17.00				
GENERAL SERVICE COST CENTERS									
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00			
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			
10.00 01000 CENTRAL SERVICES & SUPPLY						10.00			
11.00 01100 PHARMACY	22,599					11.00			
13.00 01300 SOCIAL SERVICE	0	79,762				13.00			
15.00 01500 PATIENT ACTIVITIES	0	0	483,533			15.00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00 03000 SKILLED NURSING FACILITY	21,624	79,762	278,573	4,424,416	0	30.00			
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00			
33.00 03300 OTHER LONG TERM CARE	975	0	204,960	2,901,078	0	33.00			
ANCILLARY SERVICE COST CENTERS									
40.00 04000 RADIOLOGY	0	0	0	3,395	0	40.00			
41.00 04100 LABORATORY	0	0	0	34,330	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	116,293	0	44.00			
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	129,563	0	45.00			
46.00 04600 SPEECH PATHOLOGY	0	0	0	1,682	0	46.00			
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,799	0	48.00			
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	57,988	0	49.00			
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00			
OUTPATIENT SERVICE COST CENTERS									
62.00 06200 FOHC						62.00			
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			
SPECIAL PURPOSE COST CENTERS									
89.00	SUBTOTALS (sum of lines 1-84)			22,599	79,762	483,533	7,684,544	0	89.00
NONREIMBURSABLE COST CENTERS									
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00			
91.00 09100 BARBER & BEAUTY SHOP	0	0	0	1,926	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	99.00		
100.00	TOTAL			22,599	79,762	483,533	7,686,470	0	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315318

Period:
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To 12/31/2021

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Cost Center Description		Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
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
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
13.00	01300	SOCIAL SERVICE	13.00
15.00	01500	PATIENT ACTIVITIES	15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	30.00
31.00	03100	NURSING FACILITY	31.00
33.00	03300	OTHER LONG TERM CARE	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	40.00
41.00	04100	LABORATORY	41.00
42.00	04200	INTRAVENOUS THERAPY	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	43.00
44.00	04400	PHYSICAL THERAPY	44.00
45.00	04500	OCCUPATIONAL THERAPY	45.00
46.00	04600	SPEECH PATHOLOGY	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	49.00
51.00	05100	SUPPORT SURFACES	51.00
OUTPATIENT SERVICE COST CENTERS			
62.00	06200	FOHC	62.00
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	70.00
71.00	07100	AMBULANCE	71.00
73.00	07300	CMHC	73.00
SPECIAL PURPOSE COST CENTERS			
89.00	SUBTOTALS (sum of lines 1-84)		89.00
NONREIMBURSABLE COST CENTERS			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	90.00
91.00	09100	BARBER & BEAUTY SHOP	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	92.00
93.00	09300	NONPAID WORKERS	93.00
94.00	09400	PATIENTS' LAUNDRY	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	95.00
98.00		Cross Foot Adjustments	98.00
99.00		Negative Cost Centers	99.00
100.00		TOTAL	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315318

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES					
	0	1.00		2A	3.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	7,008	7,008	0	7,008	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	7,150	7,150	0	669	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	7,832	7,832	0	325	6.00
7.00 00700	HOUSEKEEPING	0	1,846	1,846	0	277	7.00
8.00 00800	DIETARY	0	29,856	29,856	0	1,095	8.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	118	10.00
11.00 01100	PHARMACY	0	0	0	0	21	11.00
13.00 01300	SOCIAL SERVICE	0	0	0	0	73	13.00
15.00 01500	PATIENT ACTIVITIES	0	18,790	18,790	0	383	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	0	130,186	130,186	0	2,386	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00 03300	OTHER LONG TERM CARE	0	120,577	120,577	0	1,341	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	0	3	40.00
41.00 04100	LABORATORY	0	0	0	0	31	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	106	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	118	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	2	46.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	427	427	0	13	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	2,394	2,394	0	45	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
62.00 06200	FQHC						62.00
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
SPECIAL PURPOSE COST CENTERS							
89.00	SUBTOTALS (sum of lines 1-84)	0	326,066	326,066	0	7,006	89.00
NONREIMBURSABLE COST CENTERS							
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	2	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			98.00
99.00	Negative Cost Centers		0	0	0	0	99.00
100.00	TOTAL	0	326,066	326,066	0	7,008	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315318

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

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Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CENTRAL SERVICES & SUPPLY	
		5.00	6.00	7.00	8.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	7,819				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	196	8,353			6.00
7.00	00700	HOUSEKEEPING	46	0	2,169		7.00
8.00	00800	DIETARY	748	0	214	31,913	8.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	118 10.00
11.00	01100	PHARMACY	0	0	0	0	0 11.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	0 13.00
15.00	01500	PATIENT ACTIVITIES	471	0	135	0	0 15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	3,264	4,385	935	16,754	99 30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0 31.00
33.00	03300	OTHER LONG TERM CARE	3,023	3,968	865	15,159	19 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	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	11	0	3	0	0 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	60	0	17	0	0 49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS							
62.00	06200	FOHC					62.00
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
SPECIAL PURPOSE COST CENTERS							
89.00		SUBTOTALS (sum of lines 1-84)	7,819	8,353	2,169	31,913	118 89.00
NONREIMBURSABLE COST CENTERS							
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 98.00
99.00		Negative Cost Centers	0	0	0	0	0 99.00
100.00		TOTAL	7,819	8,353	2,169	31,913	118 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315318

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

Worksheet B
Part II
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Cost Center Description	PHARMACY	SOCIAL SERVICE	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments		
			PATIENT ACTIVITIES				
	11.00	13.00	15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00	
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	
10.00 01000 CENTRAL SERVICES & SUPPLY						10.00	
11.00 01100 PHARMACY	21					11.00	
13.00 01300 SOCIAL SERVICE	0	73				13.00	
15.00 01500 PATIENT ACTIVITIES	0	0	19,779			15.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 SKILLED NURSING FACILITY	20	73	11,395	169,497	0	30.00	
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00	
33.00 03300 OTHER LONG TERM CARE	1	0	8,384	153,337	0	33.00	
ANCILLARY SERVICE COST CENTERS							
40.00 04000 RADIOLOGY	0	0	0	3	0	40.00	
41.00 04100 LABORATORY	0	0	0	31	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	106	0	44.00	
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	118	0	45.00	
46.00 04600 SPEECH PATHOLOGY	0	0	0	2	0	46.00	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	454	0	48.00	
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	2,516	0	49.00	
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00	
OUTPATIENT SERVICE COST CENTERS							
62.00 06200 FOHC						62.00	
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	
SPECIAL PURPOSE COST CENTERS							
89.00	SUBTOTALS (sum of lines 1-84)					0	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00	
91.00 09100 BARBER & BEAUTY SHOP	0	0	0	2	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	98.00
99.00	Negative Cost Centers					0	99.00
100.00	21	73	19,779	326,066	0	100.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315318

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

Worksheet B
Part II
Date/Time Prepared:
5/23/2022 8:22 pm

Cost Center Description		Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
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
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
13.00	01300	SOCIAL SERVICE	13.00
15.00	01500	PATIENT ACTIVITIES	15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	30.00
31.00	03100	NURSING FACILITY	31.00
33.00	03300	OTHER LONG TERM CARE	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	40.00
41.00	04100	LABORATORY	41.00
42.00	04200	INTRAVENOUS THERAPY	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	43.00
44.00	04400	PHYSICAL THERAPY	44.00
45.00	04500	OCCUPATIONAL THERAPY	45.00
46.00	04600	SPEECH PATHOLOGY	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	49.00
51.00	05100	SUPPORT SURFACES	51.00
OUTPATIENT SERVICE COST CENTERS			
62.00	06200	FOHC	62.00
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	70.00
71.00	07100	AMBULANCE	71.00
73.00	07300	CMHC	73.00
SPECIAL PURPOSE COST CENTERS			
89.00	SUBTOTALS (sum of lines 1-84)		89.00
NONREIMBURSABLE COST CENTERS			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	90.00
91.00	09100	BARBER & BEAUTY SHOP	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	92.00
93.00	09300	NONPAID WORKERS	93.00
94.00	09400	PATIENTS' LAUNDRY	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	95.00
98.00		Cross Foot Adjustments	98.00
99.00		Negative Cost Centers	99.00
100.00		TOTAL	100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315318

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

Worksheet B-1
Date/Time Prepared:
5/23/2022 8:22 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	BLDGS & FIXTURES (SQUARE FEET)					
	1.00	3.00	4A	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	75,607				1.00
3.00 00300	EMPLOYEE BENEFITS	0	3,110,809			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,625	119,417	-1,151,050	6,535,420	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,658	8,609	0	624,069	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,816	204,899	0	302,870	6.00
7.00 00700	HOUSEKEEPING	428	135,427	0	258,476	7.00
8.00 00800	DIETARY	6,923	417,475	0	1,021,596	8.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	110,016	10.00
11.00 01100	PHARMACY	0	0	0	19,215	11.00
13.00 01300	SOCIAL SERVICE	0	51,302	0	67,818	13.00
15.00 01500	PATIENT ACTIVITIES	4,357	174,521	0	357,229	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	30,187	1,280,003	0	2,224,658	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
33.00 03300	OTHER LONG TERM CARE	27,959	719,156	0	1,250,643	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	2,887	40.00
41.00 04100	LABORATORY	0	0	0	29,189	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	98,878	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	110,161	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	1,430	46.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	99	0	0	12,208	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	555	0	0	42,439	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
62.00 06200	FOHC					62.00
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
SPECIAL PURPOSE COST CENTERS						
89.00	SUBTOTALS (sum of lines 1-84)	75,607	3,110,809	-1,151,050	6,533,782	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	1,638	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)	326,066	1,001,471		1,151,050	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	4.312643	0.321933		0.176125	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		7,008	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.001072	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315318

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

Worksheet B-1

Date/Time Prepared:
5/23/2022 8:22 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (DIRECT)	PHARMACY (DIRECT)		
		6.00	7.00	8.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
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	28,818				6.00	
7.00	00700	HOUSEKEEPING	0	70,080			7.00	
8.00	00800	DIETARY	0	6,923	28,818		8.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	110,016		10.00	
11.00	01100	PHARMACY	0	0	0	19,215	11.00	
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00	
15.00	01500	PATIENT ACTIVITIES	0	4,357	0	0	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	15,129	30,187	15,129	92,225	18,386	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	13,689	27,959	13,689	17,791	829	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	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	99	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	555	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
62.00	06200	FOHC						62.00
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
SPECIAL PURPOSE COST CENTERS								
89.00		SUBTOTALS (sum of lines 1-84)	28,818	70,080	28,818	110,016	19,215	89.00
NONREIMBURSABLE COST CENTERS								
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)	374,643	308,344	1,302,243	129,393	22,599	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	13.000312	4.399886	45.188528	1.176129	1.176112	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	8,353	2,169	31,913	118	21	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.289854	0.030950	1.107398	0.001073	0.001093	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315318

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

Worksheet B-1
Date/Time Prepared:
5/23/2022 8:22 pm

Cost Center Description	SOCIAL SERVICE (DIRECT)	OTHER GENERAL SERVICE		
		PATIENT ACTIVITIES		
		(DIRECT)	(DIRECT)	
	13.00	15.00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
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
10.00 01000 CENTRAL SERVICES & SUPPLY				10.00
11.00 01100 PHARMACY				11.00
13.00 01300 SOCIAL SERVICE	51,302			13.00
15.00 01500 PATIENT ACTIVITIES	0	282,255		15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 SKILLED NURSING FACILITY	51,302	162,613		30.00
31.00 03100 NURSING FACILITY	0	0		31.00
33.00 03300 OTHER LONG TERM CARE	0	119,642		33.00
ANCILLARY SERVICE COST CENTERS				
40.00 04000 RADIOLOGY	0	0		40.00
41.00 04100 LABORATORY	0	0		41.00
42.00 04200 INTRAVENOUS THERAPY	0	0		42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0		43.00
44.00 04400 PHYSICAL THERAPY	0	0		44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0		45.00
46.00 04600 SPEECH PATHOLOGY	0	0		46.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0		49.00
51.00 05100 SUPPORT SURFACES	0	0		51.00
OUTPATIENT SERVICE COST CENTERS				
62.00 06200 FOHC				62.00
OTHER REIMBURSABLE COST CENTERS				
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
SPECIAL PURPOSE COST CENTERS				
89.00	SUBTOTALS (sum of lines 1-84)		51,302 282,255	89.00
NONREIMBURSABLE COST CENTERS				
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
98.00	Cross Foot Adjustments			98.00
99.00	Negative Cost Centers			99.00
102.00	79,762	483,533		102.00
	Cost to be allocated (per Wkst. B, Part I)			
103.00	1.554754	1.713107		103.00
	Unit cost multiplier (Wkst. B, Part I)			
104.00	73	19,779		104.00
	Cost to be allocated (per Wkst. B, Part II)			
105.00	0.001423	0.070075		105.00
	Unit cost multiplier (Wkst. B, Part II)			

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet C	
		Date/Time Prepared: 5/23/2022 8:22 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	
ANCILLARY SERVICE COST CENTERS					
40.00	04000 RADIOLOGY	3,395	2,887	1.175961	40.00
41.00	04100 LABORATORY	34,330	29,189	1.176128	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400 PHYSICAL THERAPY	116,293	143,442	0.810732	44.00
45.00	04500 OCCUPATIONAL THERAPY	129,563	110,161	1.176124	45.00
46.00	04600 SPEECH PATHOLOGY	1,682	2,314	0.726880	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,799	11,781	1.341058	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	57,988	42,965	1.349657	49.00
51.00	05100 SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
62.00	06200 FOHC				62.00
71.00	07100 AMBULANCE	0	0	0.000000	71.00
100.00	Total	359,050	342,739		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/23/2022 8:22 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)		
		1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADIOLOGY	1.175961	1,113	0	1,309	0	40.00
41.00	04100 LABORATORY	1.176128	1,514	0	1,781	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	0.810732	63,115	0	51,169	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	1.176124	38,805	0	45,639	0	45.00
46.00	04600 SPEECH PATHOLOGY	0.726880	1,060	0	770	0	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.341058	5,736	0	7,692	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.349657	38,384	0	51,805	0	49.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
62.00	06200 FOHC						62.00
71.00	07100 AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		149,727	0	160,165	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. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Prepared: 5/23/2022 8:22 pm				
		Title XVIII	Skilled Nursing Facility	PPS				
Cost Center Description					1.00			
PART II - APPORTIONMENT OF VACCINE COST								
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		1.349657	1.00			
2.00		Program vaccine charges (From your records, or the PS&R)		3,041	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)		4,104	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	3,395	0	0.000000	1,309	0	40.00
41.00	04100	LABORATORY	34,330	0	0.000000	1,781	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	116,293	0	0.000000	51,169	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	129,563	0	0.000000	45,639	0	45.00
46.00	04600	SPEECH PATHOLOGY	1,682	0	0.000000	770	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,799	0	0.000000	7,692	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	57,988	0	0.000000	51,805	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	359,050	0		160,165	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-III Date/Time Prepared: 5/23/2022 8:22 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		15,129	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		867	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		4,424,416	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		4,732,454	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.934909	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)		4,424,416	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		292.45	16.00
17.00	Program routine service cost (Line 3 times line 16)		253,554	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)		253,554	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)		169,497	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		11.20	21.00
22.00	Program capital related cost (Line 3 times line 21)		9,710	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		243,844	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)		243,844	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	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		15,129	1.00
2.00	Program inpatient days (see instructions)		867	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)		0.057307	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 XVIII		Provider No. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Prepared: 5/23/2022 8:22 pm
		Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		550,344	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)		550,344	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		91,081	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)		459,263	11.00
12.00	Interim payments (See instructions)		459,263	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
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		4,104	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		4,104	19.00
20.00	Medicare Part B ancillary charges (See instructions)		3,041	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		3,041	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance 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)		3,041	25.00
26.00	Interim payments (See instructions)		2,129	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)		912	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. : 315318	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Prepared: 5/23/2022 8:22 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		459,263		2,129	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
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 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)		459,263		2,129	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		0		912	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		459,263		3,041	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. : 315318

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

Worksheet G

Date/Time Prepared:
5/23/2022 8:22 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	6,044,082	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	1,598,490	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	-883,592	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	276,709	0	0	0	8.00
9.00	Other current assets	0	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)	7,035,689	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	91,241	0	0	0	13.00
14.00	Less: Accumulated depreciation	-66,653	0	0	0	14.00
15.00	Buildings	6,366,135	0	0	0	15.00
16.00	Less Accumulated depreciation	-6,250,119	0	0	0	16.00
17.00	Leasehold improvements	1,192,513	0	0	0	17.00
18.00	Less: Accumulated Amortization	-866,801	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	118,857	0	0	0	21.00
22.00	Less: Accumulated depreciation	-118,858	0	0	0	22.00
23.00	Major movable equipment	390,709	0	0	0	23.00
24.00	Less: Accumulated depreciation	-261,471	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)	595,553	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	0	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	7,631,242	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	138,300	0	0	0	35.00
36.00	Salaries, wages, and fees payable	35,491	0	0	0	36.00
37.00	Payroll taxes payable	-839	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	0	0	0	0	41.00
42.00	Other current liabilities	430,918	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	603,870	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	0	0	0	0	48.00
49.00	PATIENT FUND LIABILITY	950	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	950	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	604,820	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,026,422	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)	7,026,422	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	7,631,242	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315318

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

Worksheet G-1

Date/Time Prepared:
5/23/2022 8:22 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		7,654,662		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-628,240			2.00
3.00	Total (sum of line 1 and line 2)		7,026,422		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)		7,026,422		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)		7,026,422		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. : 315318

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/23/2022 8:22 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	4,732,454		4,732,454	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	2,462,904		2,462,904	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	7,195,358		7,195,358	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	528,377	0	528,377	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)	7,723,735	0	7,723,735	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			7,691,899	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)			7,691,899	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315318

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

Worksheet G-3

Date/Time Prepared:
5/23/2022 8:22 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	7,723,735	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,464,721	2.00
3.00	Net patient revenues (Line 1 minus line 2)	6,259,014	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	7,691,899	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,432,885	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	123,448	6.00
7.00	Income from investments	5,020	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	0	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	Other miscellaneous revenue	676,177	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	804,645	25.00
26.00	Total (Line 5 plus line 25)	-628,240	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)	-628,240	31.00