

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: 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 9/7/2022 4:24 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date:	Time:
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Contractor No. <u>12001</u>	7. <input type="checkbox"/> First Cost Report for this Provider CCN
	5. Date Received: <u>06/01/2022</u>	8. <input type="checkbox"/> Last Cost Report for this Provider CCN	9. NPR Date: <u>09/23/2022</u>
		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 CONTINUING CARE AT CEDAR CREST VILLA (315491) 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	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title XVIII			Title XIX	
	Title V	Part A	Part B		
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	0	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
7.10 SNF - BASED CORF I	0		0	0	7.10
7.30 SNF - BASED OPT X	0		0	0	7.30
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. : 315491		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 9/7/2022 4:24 pm				
1.00		2.00		3.00						
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:										
1.00	Street: 4 CEDAR CREST VILLAGE DR.	PO Box:						1.00		
2.00	City: POMPTON PLAINS	State: NJ	Zip Code: 07444					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)					
		1.00	2.00	3.00	V	XVIII	XIX			
					4.00	5.00	6.00			
SNF and SNF-Based Component Identification:										
4.00	SNF	CONTINUING CARE AT CEDAR CREST VILLA	315491	04/15/2005	N	P	O	4.00		
5.00	Nursing Facility							5.00		
6.00	ICF/IID							6.00		
7.00	SNF-Based HHA	CEDAR CREST VILLAGE, INC. HOME HEALT	317092	07/23/2008	N	P	N	7.00		
8.00	SNF-Based RHC							8.00		
9.00	SNF-Based FOHC							9.00		
10.00	SNF-Based CMHC							10.00		
11.00	SNF-Based OLTC							11.00		
12.00	SNF-Based HOSPICE							12.00		
13.00	SNF-Based CORF							13.00		
13.10	SNF-Based OPT	OP REHAP AGENCY AT CEDAR CREST	316707	02/02/2005				13.10		
				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.						Y		18.00	
Miscellaneous Cost Reporting Information										
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.						N		19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.						N		19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.										
20.00	Straight Line						19,744,685		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						19,744,685		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)						Y		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 FOHC									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)						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	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 9/7/2022 4:24 pm
		Premiums	Paid Losses	Self Insurance
		1.00	2.00	3.00
41.00	List malpractice premiums and paid losses:	0	0	0
				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
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			Y
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.			H57210
		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: ERICKSON LIVING MANAGEMENT, LLC	Contractor's Name: NOVITAS SOLUTIONS		Contractor's Number: 12001
46.00	Street: 701 MAIDEN CHOICE LANE	PO Box:		
47.00	City: CATONSVILLE	State: MD	Zip Code:	21228

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 9/7/2022 4: 24 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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	04/25/2022	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. : 315491

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 9/7/2022 4:24 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.	JON	UNROE	19.00
20.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	713-499-4600	JUNROE@BKD.COM	21.00

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

Provider No. : 315491

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 9/7/2022 4:24 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.)	04/25/2022	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.	PARTNER	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

VOLUNTARY CONTACT INFORMATION		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part V Date/Time Prepared: 9/7/2022 4:24 pm
			1.00	
Cost Report Preparer Contact Information				
1.00	First Name			1.00
2.00	Last Name			2.00
3.00	Title			3.00
4.00	Employer			4.00
5.00	Phone Number			5.00
6.00	E-mail Address			6.00
7.00	Department			7.00
8.00	Mailing Address 1			8.00
9.00	Mailing Address 2			9.00
10.00	City			10.00
11.00	State			11.00
12.00	Zip			12.00
Officer or Administrator of Provider Contact Information				
13.00	First Name	Staci		13.00
14.00	Last Name	Henderson		14.00
15.00	Title			15.00
16.00	Employer			16.00
17.00	Phone Number	4104022347		17.00
18.00	E-mail Address	Staci.Henderson@erickson.com		18.00
19.00	Department			19.00
20.00	Mailing Address 1	Dept: Central Accounting		20.00
21.00	Mailing Address 2			21.00
22.00	City	Baltimore		22.00
23.00	State		MD	23.00
24.00	Zip	21228		24.00

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

Provider No. : 315491

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 9/7/2022 4: 24 pm

Component		Number of Beds		Bed Days Available		Inpatient Days/Visits				
						Title V		Title XVIII		Title XIX
						1.00	2.00	3.00	4.00	5.00
1.00	SKILLED NURSING FACILITY	113	41,245	0	4,912	4,558	1.00			
2.00	NURSING FACILITY	0	0	0		0	2.00			
3.00	ICF/IID	0	0			0	3.00			
4.00	HOME HEALTH AGENCY COST			0	4,722	0	4.00			
5.00	Other Long Term Care	0	0				5.00			
6.00	SNF-Based CMHC						6.00			
6.10	SNF-Based CORF						6.10			
6.30	SNF-Based OPT						6.30			
7.00	HOSPICE	0	0	0	0	0	7.00			
8.00	Total (Sum of lines 1-7)	113	41,245	0	9,634	4,558	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	27,102	36,572	0	190	6	1.00			
2.00	NURSING FACILITY	0	0	0		0	2.00			
3.00	ICF/IID	0	0			0	3.00			
4.00	HOME HEALTH AGENCY COST	2,345	7,067				4.00			
5.00	Other Long Term Care	0	0				5.00			
6.00	SNF-Based CMHC						6.00			
6.10	SNF-Based CORF						6.10			
6.30	SNF-Based OPT						6.30			
7.00	HOSPICE	0	0	0	0	0	7.00			
8.00	Total (Sum of lines 1-7)	29,447	43,639	0	190	6	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	241	437	0.00	25.85	759.67	1.00			
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00			
3.00	ICF/IID	0	0			0.00	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			
6.10	SNF-Based CORF						6.10			
6.30	SNF-Based OPT						6.30			
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00			
8.00	Total (Sum of lines 1-7)	241	437	0.00	25.85	759.67	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	83.69	0	203	0	245	1.00			
2.00	NURSING FACILITY	0.00	0		0	0	2.00			
3.00	ICF/IID	0.00			0	0	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			
6.10	SNF-Based CORF						6.10			
6.30	SNF-Based OPT						6.30			
7.00	HOSPICE	0.00	0	0	0	0	7.00			
8.00	Total (Sum of lines 1-7)	83.69	0	203	0	245	8.00			
Component		Admissions		Full Time Equivalent						
		Total		Employees on Payroll	Nonpaid Workers					
		21.00	22.00	23.00						
1.00	SKILLED NURSING FACILITY	448	147.37	0.00			1.00			
2.00	NURSING FACILITY	0	0.00	0.00			2.00			
3.00	ICF/IID	0	0.00	0.00			3.00			
4.00	HOME HEALTH AGENCY COST		10.73	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			
6.10	SNF-Based CORF		0.00	0.00			6.10			
6.30	SNF-Based OPT		7.56	0.00			6.30			
7.00	HOSPICE	0	0.00	0.00			7.00			
8.00	Total (Sum of lines 1-7)	448	165.66	0.00			8.00			

Provider No. : 315491

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

Worksheet S-3
Part II
Date/Time Prepared:
9/7/2022 4:24 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)	31,085,579	0	31,085,579	1,273,455.38	24.41
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)	31,085,579	0	31,085,579	1,273,455.38	24.41
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST	1,009,921	0	1,009,921	22,323.90	45.24
9.00	CMHC	0	0	0	0.00	0.00
9.10	CORF					
9.20	OPT					
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	15,375,677	0	15,375,677	735,732.59	20.90
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	16,385,598	0	16,385,598	758,056.49	21.62
13.00	Total Adjusted Salaries (line 6 minus line 12)	14,699,981	0	14,699,981	515,398.89	28.52
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	213,255	0	213,255	3,357.21	63.52
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)	8,137,593	0	8,137,593		
18.00	Wage-related costs other (See Part IV)	243,605	0	243,605		
19.00	Wage related costs (excluded units)	4,417,834	0	4,417,834		
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)	3,963,364	0	3,963,364		

SNF WAGE INDEX INFORMATION

Provider No. : 315491

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

Worksheet S-3
Part III
Date/Time Prepared:
9/7/2022 4:24 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	160,364	0	160,364	3,685.47	43.51	1.00
2.00	Administrative & General	2,813,315	0	2,813,315	71,447.42	39.38	2.00
3.00	Plant Operation, Maintenance & Repairs	1,957,722	0	1,957,722	83,418.07	23.47	3.00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4.00
5.00	Housekeeping	0	0	0	0.00	0.00	5.00
6.00	Dietary	356,630	0	356,630	8,076.66	44.16	6.00
7.00	Nursing Administration	0	0	0	0.00	0.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	0	0	0	0.00	0.00	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	1,201,924	0	1,201,924	44,616.34	26.94	13.00
14.00	Total (sum lines 1 thru 13)	6,489,955	0	6,489,955	211,243.96	30.72	14.00

SNF WAGE RELATED COSTS		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 9/7/2022 4:24 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		691,092	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)		4,096,153	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		700,359	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		2,437,557	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		188,130	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		24,302	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		8,137,593	24.00
				Amount Reported
				1.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS		243,605	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315491

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

Worksheet S-3
Part V
Date/Time Prepared:
9/7/2022 4:24 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)	730,741	0	730,741	14,841.74	49.24	1.00
2.00	Licensed Practical Nurses (LPNs)	1,748,183	0	1,748,183	44,769.68	39.05	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,910,023	0	2,910,023	130,896.00	22.23	3.00
4.00	Total Nursing (sum of lines 1 through 3)	5,388,947	0	5,388,947	190,507.42	28.29	4.00
5.00	Physical Therapists	224,722	0	224,722	4,065.38	55.28	5.00
6.00	Physical Therapy Assistants	65,381	0	65,381	1,919.82	34.06	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	271,690	0	271,690	5,491.20	49.48	8.00
9.00	Occupational Therapy Assistants	1,198	0	1,198	31.60	37.91	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	79,333	0	79,333	1,849.06	42.90	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)	22,864		22,864	254.04	90.00	14.00
15.00	Licensed Practical Nurses (LPNs)	99,697		99,697	1,175.23	84.83	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	90,695		90,695	1,927.94	47.04	16.00
17.00	Total Nursing (sum of lines 14 through 16)	213,256		213,256	3,357.21	63.52	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	0		0	0.00	0.00	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

SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet S-4	
		HHA CCN: 317092		Date/Time Prepared: 9/7/2022 4:24 pm	
		Title XVIII	Home Health Agency I	PPS	
		Title V	Title XVIII	Title XIX	Other
		1.00	2.00	3.00	4.00
HOME HEALTH AGENCY STATISTICAL DATA					
1.00	County	MORRIS			1.00
DESCRIPTION					
2.00	Home Health Aide Hours	0	456	0	239
3.00	Unduplicated Census Count (see instructions)	0.00	246.00	0.00	129.00
			Staff	Contract	Total
			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)					
4.00	Enter the number of hours in your normal work week		40.00		4.00
5.00	Administrator and Assistant Administrator(s)		0.67	0.00	0.67
6.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00
7.00	Other Administrative Personnel		1.80	0.00	1.80
8.00	Direct Nursing Service		3.26	0.00	3.26
9.00	Nursing Supervisor		1.36	0.00	1.36
10.00	Physical Therapy Service		2.26	0.00	2.26
11.00	Physical Therapy Supervisor		0.00	0.00	0.00
12.00	Occupational Therapy Service		0.89	0.00	0.89
13.00	Occupational Therapy Supervisor		0.00	0.00	0.00
14.00	Speech Pathology Service		0.16	0.00	0.16
15.00	Speech Pathology Supervisor		0.00	0.00	0.00
16.00	Medical Social Service		0.00	0.00	0.00
17.00	Medical Social Service Supervisor		0.00	0.00	0.00
18.00	Home Health Aide		0.33	0.00	0.33
19.00	Home Health Aide Supervisor		0.00	0.00	0.00
20.00	Other (specify)		0.00	0.00	0.00
HOME HEALTH AGENCY CBSA CODES					
21.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1		21.00
22.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 22 contains the first code).	35084			22.00
		Full Episodes			
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes
		1.00	2.00	3.00	4.00
				Total (columns 1 through 4)	5.00
PPS ACTIVITY DATA					
23.00	Skilled Nursing Visits	1,662	165	121	0
24.00	Skilled Nursing Visit Charges	290,675	28,875	21,175	0
25.00	Physical Therapy Visits	1,507	133	30	0
26.00	Physical Therapy Visit Charges	301,200	26,600	6,000	0
27.00	Occupational Therapy Visits	515	93	4	0
28.00	Occupational Therapy Visit Charges	103,000	18,600	800	0
29.00	Speech Pathology Visits	100	49	0	0
30.00	Speech Pathology Visit Charges	20,000	9,800	0	0
31.00	Medical Social Service Visits	2	0	1	0
32.00	Medical Social Service Visit Charges	400	0	200	0
33.00	Home Health Aide Visits	298	42	0	0
34.00	Home Health Aide Visit Charges	37,250	5,250	0	0
35.00	Total visits (sum of lines 23, 25, 27, 29, 31, and 33)	4,084	482	156	0
36.00	Other Charges	0	0	0	0
37.00	Total Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36)	752,525	89,125	28,175	0
38.00	Total Number of Episodes (standard/non outlier)	395		108	0
39.00	Total Number of Outlier Episodes		16		0
40.00	Total Non-Routine Medical Supply Charges	5,726	447	1,217	0
		Total			
		5.00			
HOME HEALTH AGENCY STATISTICAL DATA					
1.00	County				1.00
DESCRIPTION					
2.00	Home Health Aide Hours	695			2.00
3.00	Unduplicated Census Count (see instructions)	375.00			3.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315491

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

Worksheet S-7

Date/Time Prepared:
9/7/2022 4:24 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. : 315491

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

Worksheet S-7

Date/Time Prepared:
9/7/2022 4:24 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. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prepared: 9/7/2022 4:24 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		24,272,609	24,272,609	0	24,272,609	1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		4,898,635	4,898,635	0	4,898,635	2.00
3.00 00300	EMPLOYEE BENEFITS	160,364	8,381,198	8,541,562	0	8,541,562	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,813,315	6,018,855	8,832,170	-122,016	8,710,154	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,957,722	1,476,084	3,433,806	0	3,433,806	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00 00700	HOUSEKEEPING	0	0	0	0	0	7.00
8.00 00800	DIETARY	356,630	156,291	512,921	0	512,921	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	0	0	0	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	OTHER GENERAL SERVICES	1,201,924	380,068	1,581,992	0	1,581,992	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	7,567,702	3,236,464	10,804,166	43,056	10,847,222	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	59,712	59,712	0	59,712	40.00
41.00 04100	LABORATORY	0	19,892	19,892	0	19,892	41.00
42.00 04200	INTRAVENOUS THERAPY	0	31,532	31,532	0	31,532	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	9,165	9,165	0	9,165	43.00
44.00 04400	PHYSICAL THERAPY	290,103	0	290,103	0	290,103	44.00
45.00 04500	OCCUPATIONAL THERAPY	272,888	590	273,478	0	273,478	45.00
46.00 04600	SPEECH PATHOLOGY	79,333	0	79,333	0	79,333	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	163,916	163,916	0	163,916	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	285,942	285,942	0	285,942	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	5,823	5,823	0	5,823	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	1,009,921	158,751	1,168,672	0	1,168,672	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	0	72.00
72.10 07210	OPT	780,241	71,944	852,185	0	852,185	72.10
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	0	80.00
81.00 08100	INTEREST EXPENSE	0	0	0	0	0	81.00
82.00 08200	UTILIZATION REVIEW	0	0	0	0	0	82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	16,490,143	49,627,471	66,117,614	-78,960	66,038,654	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	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 CENTER	13,277,543	14,092,453	27,369,996	78,960	27,448,956	95.00
95.01 09501	MARKETING	1,317,893	2,790,623	4,108,516	0	4,108,516	95.01
100.00	TOTAL	31,085,579	66,510,547	97,596,126	0	97,596,126	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prepared: 9/7/2022 4:24 pm
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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	-295,728	23,976,881	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	4,898,635	2.00
3.00	00300	EMPLOYEE BENEFITS	-57,470	8,484,092	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-4,355,746	4,354,408	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	3,433,806	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	6.00
7.00	00700	HOUSEKEEPING	0	0	7.00
8.00	00800	DIETARY	-139,727	373,194	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	OTHER GENERAL SERVICES	-36,282	1,545,710	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-448,987	10,398,235	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	59,712	40.00
41.00	04100	LABORATORY	0	19,892	41.00
42.00	04200	INTRAVENOUS THERAPY	0	31,532	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	9,165	43.00
44.00	04400	PHYSICAL THERAPY	0	290,103	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	273,478	45.00
46.00	04600	SPEECH PATHOLOGY	0	79,333	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	163,916	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	-70	285,872	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	5,823	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	52.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	-39,200	1,129,472	70.00
71.00	07100	AMBULANCE	0	0	71.00
72.00	07200	CORF	0	0	72.00
72.10	07210	OPT	6,380	858,565	72.10
73.00	07300	CMHC	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	-5,366,830	60,671,824	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	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 CENTER	-31,580	27,417,376	95.00
95.01	09501	MARKETING	-2,243	4,106,273	95.01
100.00		TOTAL	-5,400,653	92,195,473	100.00

RECLASSIFICATIONS

Provider No. : 315491

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

Worksheet A-6

Date/Time Prepared:
9/7/2022 4:24 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
	(1) A - MEDICAL DIRECTOR RECLASS					
1.00		SKILLED NURSING FACILITY	30.00	0	43,056	1.00
2.00		OTHER NONREIMBURSABLE COST CENTER	95.00	0	78,960	2.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		0	122,016	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.

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
	(1) A - MEDICAL DIRECTOR RECLASS	6.00	7.00	8.00	9.00	
1.00		ADMINISTRATIVE & GENERAL	4.00	0	122,016	1.00
2.00			0.00	0	0	2.00
	TOTALS					
100.00				0	122,016	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. : 315491

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

Worksheet A-7

Date/Time Prepared:
9/7/2022 4:24 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	13,507,764	0	0	0	0	1.00
2.00 Land Improvements	1,608,675	146,088	0	146,088	0	2.00
3.00 Buildings and Fixtures	458,699,902	13,910,606	0	13,910,606	1,535,916	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	1,897,737	490,036	0	490,036	0	5.00
6.00 Movable Equipment	30,878,805	988,139	0	988,139	969,063	6.00
7.00 Subtotal (sum of lines 1-6)	506,592,883	15,534,869	0	15,534,869	2,504,979	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	506,592,883	15,534,869	0	15,534,869	2,504,979	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	13,507,764	0				
2.00 Land Improvements	1,754,763	0				
3.00 Buildings and Fixtures	471,074,592	0				
4.00 Building Improvements	0	0				
5.00 Fixed Equipment	2,387,773	0				
6.00 Movable Equipment	30,897,881	0				
7.00 Subtotal (sum of lines 1-6)	519,622,773	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	519,622,773	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315491

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

Worksheet A-8

Date/Time Prepared:
9/7/2022 4:24 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)		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	-3,906,883				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	B	-141	ADMINISTRATIVE & GENERAL		4.00	18.00
19.00 Vending machines	B	-1,917	OTHER NONREIMBURSABLE COST CENTER		95.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW		82.00	22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT		2.00	24.00
25.00 CONTRIBUTIONS EXPENSE	A	-507,135	ADMINISTRATIVE & GENERAL		4.00	25.00
25.01 GIFT SHOP REVENUE	B	-252,946	OTHER NONREIMBURSABLE COST CENTER		95.00	25.01
25.02 GUEST ROOM RENT REVENUE	B	-40,690	OTHER NONREIMBURSABLE COST CENTER		95.00	25.02
25.03 LIQUOR	A	44	SKILLED NURSING FACILITY		30.00	25.03
25.04 LIQUOR	A	-181	DIETARY		8.00	25.04
25.05 LIQUOR	A	-1,797	SKILLED NURSING FACILITY		30.00	25.05
25.06 ADVERTISING AND PR EXPENSE	A	-29	EMPLOYEE BENEFITS		3.00	25.06
25.07 ADVERTISING AND PR EXPENSE	A	-674	MARKETING		95.01	25.07
25.08 ADVERTISING AND PR EXPENSE	A	-190	MARKETING		95.01	25.08
25.09 ADVERTISING AND PR EXPENSE	A	-1,191	MARKETING		95.01	25.09
25.10 LIQUOR	A	-30,299	OTHER NONREIMBURSABLE COST CENTER		95.00	25.10
25.11 LIQUOR	A	-1,342	OTHER NONREIMBURSABLE COST CENTER		95.00	25.11
25.12 LIQUOR	A	-4,423	OTHER NONREIMBURSABLE COST CENTER		95.00	25.12
25.13 LIQUOR	A	-3,609	OTHER NONREIMBURSABLE COST CENTER		95.00	25.13
25.14 LIQUOR	A	346	OTHER NONREIMBURSABLE COST CENTER		95.00	25.14
25.15 LIQUOR	A	-79	OTHER NONREIMBURSABLE COST CENTER		95.00	25.15
25.16 ADVERTISING AND PR EXPENSE	A	-136	OTHER NONREIMBURSABLE COST CENTER		95.00	25.16
25.17 GIFTS	A	-620	ADMINISTRATIVE & GENERAL		4.00	25.17
25.18 GIFTS	A	-70	DRUGS CHARGED TO PATIENTS		49.00	25.18
25.19 GIFTS	A	-670	OTHER NONREIMBURSABLE COST CENTER		95.00	25.19

Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Date/Time Prepared: 9/7/2022 4:24 pm
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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	
25.20 LIQUOR	A	-188	MARKETING	95.01	25.20
25.21 BAD DEBT	A	-135,781	SKILLED NURSING FACILITY	30.00	25.21
25.22 BAD DEBT	A	-61,752	ADMINISTRATIVE & GENERAL	4.00	25.22
25.23 BAD DEBT	A	-20,854	HOME HEALTH AGENCY COST	70.00	25.23
25.24 BAD DEBT	A	-23,851	OPT	72.10	25.24
25.25 LEASE REVENUE	B	-107,867	OTHER NONREIMBURSABLE COST CENTER	95.00	25.25
25.26 INTEREST INCOME -	B	-295,728	CAP REL COSTS - BLDGS & FIXTURES	1.00	25.26
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-5,400,653			100.00

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
- (2) Basis for adjustment (see instructions).
 - A. Costs - if cost, including applicable overhead, can be determined.
 - B. Amount Received - if cost cannot be determined.

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

Provider No. : 315491

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
9/7/2022 4:24 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		3.00	EMPLOYEE BENEFITS	HOME OFFICE COSTS	1.00
2.00		4.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	2.00
3.00		8.00	DIETARY	HOME OFFICE COSTS	3.00
4.00		15.00	OTHER GENERAL SERVICES	HOME OFFICE COSTS	4.00
5.00		30.00	SKILLED NURSING FACILITY	HOME OFFICE COSTS	5.00
6.00		70.00	HOME HEALTH AGENCY COST	HOME OFFICE COSTS	6.00
7.00		72.10	OPT	HOME OFFICE COSTS	7.00
8.00		95.00	OTHER NONREIMBURSABLE COST CENTER	HOME OFFICE COSTS	8.00
9.00		0.00			9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.				10.00
		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
		4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		0	57,441	-57,441	1.00
2.00		0	3,786,098	-3,786,098	2.00
3.00		0	139,546	-139,546	3.00
4.00		0	36,282	-36,282	4.00
5.00		748,341	1,059,794	-311,453	5.00
6.00		66,351	84,697	-18,346	6.00
7.00		50,760	20,529	30,231	7.00
8.00		3,903,316	3,491,264	412,052	8.00
9.00		0	0	0	9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	4,768,768	8,675,651	-3,906,883	10.00

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

Provider No. : 315491

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

Worksheet A-8-1
Parts I-II
Date/Time Prepared:
9/7/2022 4:24 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00		B	0.00	1.00
2.00			0.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00	ERICKSON LIVING MGMT, LLC	0.00	CCRC/MGMT/DVPM	1.00
2.00		0.00		2.00
3.00		0.00		3.00
4.00		0.00		4.00
5.00		0.00		5.00
6.00		0.00		6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:	0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315491

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

Worksheet B
Part I
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	23,976,881	23,976,881			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	4,898,635		4,898,635		2.00
3.00 00300	EMPLOYEE BENEFITS	8,484,092	0	0	8,484,092	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	4,354,408	0	0	771,810	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	3,433,806	0	0	537,085	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00 00700	HOUSEKEEPING	0	0	0	0	7.00
8.00 00800	DIETARY	373,194	0	0	97,839	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	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	0	0	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	OTHER GENERAL SERVICES	1,545,710	0	0	329,738	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	10,398,235	1,389,907	283,967	2,076,139	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	59,712	0	0	0	40.00
41.00 04100	LABORATORY	19,892	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	31,532	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	9,165	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	290,103	0	0	79,587	44.00
45.00 04500	OCCUPATIONAL THERAPY	273,478	0	0	74,865	45.00
46.00 04600	SPEECH PATHOLOGY	79,333	0	0	21,764	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,916	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	285,872	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	5,823	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	1,129,472	13,045	2,665	277,064	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	72.00
72.10 07210	OPT	858,565	25,415	5,192	214,053	72.10
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	60,671,824	1,428,367	291,824	4,479,944	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	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 CENTER	27,417,376	22,548,514	4,606,811	3,642,595	95.00
95.01 09501	MARKETING	4,106,273	0	0	361,553	95.01
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	92,195,473	23,976,881	4,898,635	8,484,092	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315491

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

Worksheet B
Part I
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL	5,126,218				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	233,786	4,204,677			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	0		6.00
7.00	00700	HOUSEKEEPING	0	0	0		7.00
8.00	00800	DIETARY	27,732	0	0	498,765	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	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	OTHER GENERAL SERVICES	110,417	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	832,978	243,739	0	70,132	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	3,516	0	0	0	40.00
41.00	04100	LABORATORY	1,171	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	1,856	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	540	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	21,765	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	20,509	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	5,952	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,651	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	16,831	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	343	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	83,735	2,288	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	72.00
72.10	07210	OPT	64,952	4,457	0	0	72.10
73.00	07300	CMHC	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	1,435,734	250,484	0	70,132	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	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 CENTER	3,427,441	3,954,193	0	428,633	95.00
95.01	09501	MARKETING	263,043	0	0	0	95.01
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	5,126,218	4,204,677	0	498,765	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315491

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		9.00	10.00	11.00	12.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
3.00	00300						3.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900	0					9.00	
10.00	01000	0	0				10.00	
11.00	01100	0	0	0			11.00	
12.00	01200	0	0	0	0		12.00	
13.00	01300	0	0	0	0	0	13.00	
14.00	01400	0	0	0	0	0	14.00	
15.00	01500	0	0	0	0	0	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	0	0	0	0	30.00	
31.00	03100	0	0	0	0	0	31.00	
32.00	03200	0	0	0	0	0	32.00	
33.00	03300	0	0	0	0	0	33.00	
ANCILLARY SERVICE COST CENTERS								
40.00	04000	0	0	0	0	0	40.00	
41.00	04100	0	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	0	0	0	0	0	43.00	
44.00	04400	0	0	0	0	0	44.00	
45.00	04500	0	0	0	0	0	45.00	
46.00	04600	0	0	0	0	0	46.00	
47.00	04700	0	0	0	0	0	47.00	
48.00	04800	0	0	0	0	0	48.00	
49.00	04900	0	0	0	0	0	49.00	
50.00	05000	0	0	0	0	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
52.00	05200	0	0	0	0	0	52.00	
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
63.00	06300	0	0	0	0	0	63.00	
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
72.10	07210	0	0	0	0	0	72.10	
73.00	07300	0	0	0	0	0	73.00	
74.00	07400	0	0	0	0	0	74.00	
SPECIAL PURPOSE COST CENTERS								
80.00	08000						80.00	
81.00	08100						81.00	
82.00	08200						82.00	
83.00	08300	0	0	0	0	0	83.00	
84.00	08400	0	0	0	0	0	84.00	
89.00	SUBTOTALS (sum of lines 1-84)						0	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	09300	0	0	0	0	0	93.00	
94.00	09400	0	0	0	0	0	94.00	
95.00	09500	0	0	0	0	0	95.00	
95.01	09501	0	0	0	0	0	95.01	
98.00	Cross Foot Adjustments						0	98.00
99.00	Negative Cost Centers						0	99.00
100.00	TOTAL						0	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315491

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

Worksheet B
Part I
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		S				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	OTHER GENERAL SERVICES	0	1,985,865			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	112,106	15,407,203	0	15,407,203
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	63,228	0	63,228
41.00 04100	LABORATORY	0	0	21,063	0	21,063
42.00 04200	INTRAVENOUS THERAPY	0	0	33,388	0	33,388
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	9,705	0	9,705
44.00 04400	PHYSICAL THERAPY	0	0	391,455	0	391,455
45.00 04500	OCCUPATIONAL THERAPY	0	0	368,852	0	368,852
46.00 04600	SPEECH PATHOLOGY	0	0	107,049	0	107,049
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	173,567	0	173,567
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	302,703	0	302,703
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	6,166	0	6,166
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	1,508,269	0	1,508,269
71.00 07100	AMBULANCE	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	72.00
72.10 07210	OPT	0	0	1,172,634	0	1,172,634
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	112,106	19,565,282	0	19,565,282
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND 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 CENTER	0	1,873,759	67,899,322	0	67,899,322
95.01 09501	MARKETING	0	0	4,730,869	0	4,730,869
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	0	1,985,865	92,195,473	0	92,195,473

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315491

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

Worksheet B
Part II
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDGS & FIXTURES	MOVABLE EQUIPMENT		
		0	1.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	0	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	0	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICES	0	0	0	6.00
7.00 00700	HOUSEKEEPING	0	0	0	7.00
8.00 00800	DIETARY	0	0	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	0	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	14.00
15.00 01500	OTHER GENERAL SERVICES	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	SKILLED NURSING FACILITY	0	1,389,907	283,967	1,673,874
31.00 03100	NURSING FACILITY	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00 04000	RADIOLOGY	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS					
60.00 06000	CLINIC	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	61.00
62.00 06200	FOHC	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00 07000	HOME HEALTH AGENCY COST	0	13,045	2,665	15,710
71.00 07100	AMBULANCE	0	0	0	71.00
72.00 07200	CORF	0	0	0	72.00
72.10 07210	OPT	0	25,415	5,192	30,607
73.00 07300	CMHC	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00 08100	INTEREST EXPENSE				81.00
82.00 08200	UTILIZATION REVIEW				82.00
83.00 08300	HOSPICE	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1,428,367	291,824	1,720,191
NONREIMBURSABLE COST CENTERS					
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST CENTER	0	22,548,514	4,606,811	27,155,325
95.01 09501	MARKETING	0	0	0	95.01
98.00	Cross Foot Adjustments				98.00
99.00	Negative Cost Centers		0	0	99.00
100.00	TOTAL	0	23,976,881	4,898,635	28,875,516

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315491		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 9/7/2022 4:24 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	0			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	0		6.00
7.00	00700	HOUSEKEEPING	0	0	0	0	7.00
8.00	00800	DIETARY	0	0	0	0	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	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	0	0	0	0	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	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
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC					62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	72.00
72.10	07210	OPT	0	0	0	0	72.10
73.00	07300	CMHC	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	0	0	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	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 CENTER	0	0	0	0	95.00
95.01	09501	MARKETING	0	0	0	0	95.01
98.00		Cross Foot Adjustments					98.00
99.00		Negative Cost Centers	0	0	0	0	99.00
100.00		TOTAL	0	0	0	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 9/7/2022 4:24 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
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
3.00	00300					3.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900	0				9.00
10.00	01000	0	0			10.00
11.00	01100	0	0	0		11.00
12.00	01200	0	0	0	0	12.00
13.00	01300	0	0	0	0	13.00
14.00	01400	0	0	0	0	14.00
15.00	01500	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	0	0	0	30.00
31.00	03100	0	0	0	0	31.00
32.00	03200	0	0	0	0	32.00
33.00	03300	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00	04000	0	0	0	0	40.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	0	0	0	0	43.00
44.00	04400	0	0	0	0	44.00
45.00	04500	0	0	0	0	45.00
46.00	04600	0	0	0	0	46.00
47.00	04700	0	0	0	0	47.00
48.00	04800	0	0	0	0	48.00
49.00	04900	0	0	0	0	49.00
50.00	05000	0	0	0	0	50.00
51.00	05100	0	0	0	0	51.00
52.00	05200	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	0	0	0	0	60.00
61.00	06100	0	0	0	0	61.00
62.00	06200	0	0	0	0	62.00
63.00	06300	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00	07000	0	0	0	0	70.00
71.00	07100	0	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
72.10	07210	0	0	0	0	72.10
73.00	07300	0	0	0	0	73.00
74.00	07400	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00	08000					80.00
81.00	08100					81.00
82.00	08200					82.00
83.00	08300	0	0	0	0	83.00
84.00	08400	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)					0
NONREIMBURSABLE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	0	0	91.00
92.00	09200	0	0	0	0	92.00
93.00	09300	0	0	0	0	93.00
94.00	09400	0	0	0	0	94.00
95.00	09500	0	0	0	0	95.00
95.01	09501	0	0	0	0	95.01
98.00	Cross Foot Adjustments					0
99.00	Negative Cost Centers					0
100.00	TOTAL					0

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315491

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

Worksheet B
Part II
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
		S				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	OTHER GENERAL SERVICES	0	0			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	0	1,673,874	0	1,673,874
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	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
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	15,710	0	15,710
71.00 07100	AMBULANCE	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	72.00
72.10 07210	OPT	0	0	30,607	0	30,607
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	0	1,720,191	0	1,720,191
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND 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 CENTER	0	0	27,155,325	0	27,155,325
95.01 09501	MARKETING	0	0	0	0	95.01
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	0	0	28,875,516	0	28,875,516

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315491

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

Worksheet B-1
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	2,275,524					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		2,275,524				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	30,925,215			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	0	2,813,315	-5,126,218	87,069,255	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	0	1,957,722	0	3,970,891	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00 00700	HOUSEKEEPING	0	0	0	0	0	7.00
8.00 00800	DIETARY	0	0	356,630	0	471,033	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	0	0	0	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	OTHER GENERAL SERVICES	0	0	1,201,924	0	1,875,448	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	131,909	131,909	7,567,702	0	14,148,248	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	0	59,712	40.00
41.00 04100	LABORATORY	0	0	0	0	19,892	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	31,532	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	9,165	43.00
44.00 04400	PHYSICAL THERAPY	0	0	290,103	0	369,690	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	272,888	0	348,343	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	79,333	0	101,097	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	163,916	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	285,872	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	5,823	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	1,238	1,238	1,009,921	0	1,422,246	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	0	72.00
72.10 07210	OPT	2,412	2,412	780,241	0	1,103,225	72.10
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	135,559	135,559	16,329,779	-5,126,218	24,386,133	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	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 CENTER	2,139,965	2,139,965	13,277,543	0	58,215,296	95.00
95.01 09501	MARKETING	0	0	1,317,893	0	4,467,826	95.01
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)	23,976,881	4,898,635	8,484,092		5,126,218	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	10.536861	2.152750	0.274342		0.058875	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		0	104.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315491

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

Worksheet B-1

Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
105.00 Unit cost multiplier (Wkst. B, Part 11)			0.000000	4A	0.000000	105.00	

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315491

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

Worksheet B-1

Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATI ENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	2,275,524				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0			6.00
7.00	00700	HOUSEKEEPING	0	0	0		7.00
8.00	00800	DIETARY	0	0	0	780,278	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	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	131,909	0	0	109,716	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	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
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	1,238	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	72.00
72.10	07210	OPT	2,412	0	0	0	72.10
73.00	07300	CMHC	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	135,559	0	0	109,716	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	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 CENTER	2,139,965	0	0	670,562	95.00
95.01	09501	MARKETING	0	0	0	0	95.01
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)	4,204,677	0	0	498,765	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	1.847784	0.000000	0.000000	0.639214	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315491

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

Worksheet B-1
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (TOTAL PATIENT DAYS)	PHARMACY (TOTAL PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (TOTAL PATIENT DAYS)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE					6.00
7.00	00700	HOUSEKEEPING					7.00
8.00	00800	DIETARY					8.00
9.00	00900	NURSING ADMINISTRATION					9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0				10.00
11.00	01100	PHARMACY	0	0			11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0		12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	0	0	0	0	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	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
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	72.00
72.10	07210	OPT	0	0	0	0	72.10
73.00	07300	CMHC	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	0	0	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	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 CENTER	0	0	0	0	95.00
95.01	09501	MARKETING	0	0	0	0	95.01
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)	0	0	0	0	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315491

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

Worksheet B-1
Date/Time Prepared:
9/7/2022 4:24 pm

Cost Center Description		OTHER GENERAL SERVICE	
		S (PATIENT DAYS)	
		15.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01500	OTHER GENERAL SERVICES	647,840
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	36,572
31.00	03100	NURSING FACILITY	0
32.00	03200	ICF/IID	0
33.00	03300	OTHER LONG TERM CARE	0
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	0
41.00	04100	LABORATORY	0
42.00	04200	INTRAVENOUS THERAPY	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0
44.00	04400	PHYSICAL THERAPY	0
45.00	04500	OCCUPATIONAL THERAPY	0
46.00	04600	SPEECH PATHOLOGY	0
47.00	04700	ELECTROCARDIOLOGY	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0
51.00	05100	SUPPORT SURFACES	0
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0
OUTPATIENT SERVICE COST CENTERS			
60.00	06000	CLINIC	0
61.00	06100	RURAL HEALTH CLINIC	0
62.00	06200	FOHC	0
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	0
71.00	07100	AMBULANCE	0
72.00	07200	CORF	0
72.10	07210	OPT	0
73.00	07300	CMHC	0
74.00	07400	OTHER REIMBURSABLE COST	0
SPECIAL PURPOSE COST CENTERS			
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	
81.00	08100	INTEREST EXPENSE	
82.00	08200	UTILIZATION REVIEW	
83.00	08300	HOSPICE	0
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0
89.00		SUBTOTALS (sum of lines 1-84)	36,572
NONREIMBURSABLE COST CENTERS			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0
91.00	09100	BARBER AND BEAUTY SHOP	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0
93.00	09300	NONPAID WORKERS	0
94.00	09400	PATIENTS LAUNDRY	0
95.00	09500	OTHER NONREIMBURSABLE COST CENTER	611,268
95.01	09501	MARKETING	0
98.00		Cross Foot Adjustments	
99.00		Negative Cost Centers	
102.00		Cost to be allocated (per Wkst. B, Part I)	1,985,865
103.00		Unit cost multiplier (Wkst. B, Part I)	3.065363
104.00		Cost to be allocated (per Wkst. B, Part II)	0
105.00		Unit cost multiplier (Wkst. B, Part II)	0.000000

RATIO OF COST TO CHARGES FOR ANCI LLARY AND OUTPATIENT COST CENTERS		Provi der No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet C Date/Time Prepared: 9/7/2022 4: 24 pm	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 di vi ded by col. 2)	
		1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	63,228	41,774	1.513573 40.00
41.00	04100	LABORATORY	21,063	28,835	0.730466 41.00
42.00	04200	INTRAVENOUS THERAPY	33,388	50,238	0.664597 42.00
43.00	04300	OXYGEN (I NHALATION) THERAPY	9,705	0	0.000000 43.00
44.00	04400	PHYSI CAL THERAPY	391,455	647,737	0.604343 44.00
45.00	04500	OCCUPATIONAL THERAPY	368,852	594,113	0.620845 45.00
46.00	04600	SPEECH PATHOLOGY	107,049	112,316	0.953106 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000 47.00
48.00	04800	MEDICAL SUPPLI ES CHARGED TO PATI ENTS	173,567	5,316	32.649925 48.00
49.00	04900	DRUGS CHARGED TO PATI ENTS	302,703	256,421	1.180492 49.00
50.00	05000	DENTAL CARE - TITL E XI X ONLY	0	0	0.000000 50.00
51.00	05100	SUPPORT SURFACES	6,166	792	7.785354 51.00
52.00	05200	OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0.000000 52.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLI NI C	0	0	0.000000 60.00
61.00	06100	RURAL HEALTH CLI NI C			61.00
62.00	06200	FOHC			62.00
63.00	06300	OTHER OUTPATIENT SERVI CE COST CENTER	0	0	0.000000 63.00
71.00	07100	AMBULANCE	0	0	0.000000 71.00
100.00		Total	1,477,176	1,737,542	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 9/7/2022 4:24 pm			
		Title XVIII (1)	Skilled Nursing Facility	PPS			
		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)		
Ratio of Cost to Charges (Fr. Wkst. C Column 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	1.513573	18,598	0	28,149	0	40.00
41.00	04100 LABORATORY	0.730466	5,844	0	4,269	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.664597	31,996	0	21,264	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	0.604343	369,958	0	223,582	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0.620845	353,106	0	219,224	0	45.00
46.00	04600 SPEECH PATHOLOGY	0.953106	56,001	0	53,375	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	32.649925	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.180492	202,390	0	238,920	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	7.785354	0	0	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0.000000	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC						61.00
62.00	06200 FOHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	63.00
71.00	07100 AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		1,037,893	0	788,783	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. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Prepared: 9/7/2022 4:24 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)		1.180492	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	63,228	0	0.000000	28,149	0	40.00
41.00	04100	LABORATORY	21,063	0	0.000000	4,269	0	41.00
42.00	04200	INTRAVENOUS THERAPY	33,388	0	0.000000	21,264	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	9,705	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	391,455	0	0.000000	223,582	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	368,852	0	0.000000	219,224	0	45.00
46.00	04600	SPEECH PATHOLOGY	107,049	0	0.000000	53,375	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	173,567	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	302,703	0	0.000000	238,920	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	6,166	0	0.000000	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	52.00
100.00		Total (Sum of lines 40 - 52)	1,477,176	0		788,783	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-III Date/Time Prepared: 9/7/2022 4: 24 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	36,572	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	4,912	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	15,407,203	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	18,003,051	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.855811	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)	15,407,203	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	421.28	16.00
17.00	Program routine service cost (Line 3 times line 16)	2,069,327	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	2,069,327	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	1,673,874	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	45.77	21.00
22.00	Program capital related cost (Line 3 times line 21)	224,822	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,844,505	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,844,505	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	36,572	1.00
2.00	Program inpatient days (see instructions)	4,912	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)	0.134310	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. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Prepared: 9/7/2022 4:24 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)		3,139,521	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)		3,139,521	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinurance		364,927	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)		2,774,594	11.00
12.00	Interim payments (See instructions)		2,774,594	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)		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. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part II Date/Time Prepared: 9/7/2022 4:24 pm
		Title XIX	Skilled Nursing Facility	Cost
				1.00
COMPUTATION OF NET COST OF COVERED SERVICES				
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
REASONABLE CHARGES				
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
CUSTOMARY CHARGES				
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
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Prepared: 9/7/2022 4:24 pm		
		Title XVIII	Skilled Nursing Facility	PPS		
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		2,774,594		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)		2,774,594		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		0		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,774,594		0	7.00
			Contractor Name		Contractor Number	
			1.00	2.00		
8.00	Name of Contractor	Novitas Solutions		12001		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. : 315491

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

Worksheet G

Date/Time Prepared:
9/7/2022 4: 24 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	10,498,218	0	0	0	1.00
2.00	Temporary investments	192,637	0	0	0	2.00
3.00	Notes receivable	2,789,800	0	0	0	3.00
4.00	Accounts receivable	2,824,972	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	-378,036	0	0	0	6.00
7.00	Inventory	294,363	0	0	0	7.00
8.00	Prepaid expenses	412,367	0	0	0	8.00
9.00	Other current assets	20,630,619	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)	37,264,940	0	0	0	11.00
FIXED ASSETS						
12.00	Land	13,507,764	0	0	0	12.00
13.00	Land improvements	1,754,763	0	0	0	13.00
14.00	Less: Accumulated depreciation	-497,437	0	0	0	14.00
15.00	Buildings	471,074,592	0	0	0	15.00
16.00	Less Accumulated depreciation	-166,209,979	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	2,387,773	0	0	0	19.00
20.00	Less: Accumulated depreciation	-1,355,895	0	0	0	20.00
21.00	Automobiles and trucks	1,008,941	0	0	0	21.00
22.00	Less: Accumulated depreciation	-744,631	0	0	0	22.00
23.00	Major movable equipment	29,888,940	0	0	0	23.00
24.00	Less: Accumulated depreciation	-21,283,751	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	9,018,226	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	338,549,306	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	81,685,049	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	1,341,309	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	83,026,358	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	458,840,604	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	4,354,961	0	0	0	35.00
36.00	Salaries, wages, and fees payable	2,958,975	0	0	0	36.00
37.00	Payroll taxes payable	656,079	0	0	0	37.00
38.00	Notes & loans payable (Short term)	923,708	0	0	0	38.00
39.00	Deferred income	70,845	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	-1,994,398	0	0	0	41.00
42.00	Other current liabilities	422,467,815	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	429,437,985	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	110,414,130	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	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	110,414,130	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	539,852,115	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-81,011,511	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)	-81,011,511	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	458,840,604	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315491

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

Worksheet G-1

Date/Time Prepared:
9/7/2022 4:24 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		-81,642,972			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-824,858				2.00
3.00	Total (sum of line 1 and line 2)		-82,467,830			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	INTERCOMPANY ADJUSTMENT	1,456,319		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		1,456,319			0	10.00
11.00	Subtotal (line 3 plus line 10)		-81,011,511			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-81,011,511			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	INTERCOMPANY ADJUSTMENT		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. : 315491

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
9/7/2022 4:24 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	18,003,051		18,003,051	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	18,003,051		18,003,051	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,737,542	0	1,737,542	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		3,998,510	3,998,510	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
11.10	CORF		0	0	11.10
11.30	OPT		1,086,944	1,086,944	11.30
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)	19,740,593	5,085,454	24,826,047	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			97,596,126	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)			97,596,126	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315491

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

Worksheet G-3

Date/Time Prepared:
9/7/2022 4:24 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	24,826,047	1.00
2.00	Less: contractual allowances and discounts on patients accounts	4,958,863	2.00
3.00	Net patient revenues (Line 1 minus line 2)	19,867,184	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	97,596,126	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-77,728,942	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	397,114	6.00
7.00	Income from investments	5,151,540	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	519,610	14.00
15.00	Revenue from rental of living quarters	40,690	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	141	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	252,946	20.00
21.00	Rental of vending machines	1,917	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other miscellaneous revenue (specify)	70,540,126	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	76,904,084	25.00
26.00	Total (Line 5 plus line 25)	-824,858	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)	-824,858	31.00

ANALYSIS OF SNF-BASED HOME HEALTH AGENCY COSTS

Provider No. : 315491

Period: From 01/01/2021

Worksheet H

HHA CCN: 317092

To 12/31/2021

Date/Time Prepared: 9/7/2022 4:24 pm

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	324,153	0	0	0	147,256	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	295,120	0	0	0	0	6.00
7.00	Physical Therapy	270,633	0	0	0	0	7.00
8.00	Occupational Therapy	96,539	0	0	0	0	8.00
9.00	Speech Pathology	13,401	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	136	0	10.00
11.00	Home Health Aide	10,075	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	11,359	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
15.00	Telemedicine	0	0	0	0	0	15.00
HHA NONREIMBURSABLE SERVICES							
16.00	Home Dialysis Aide Services	0	0	0	0	0	16.00
17.00	Respiratory Therapy	0	0	0	0	0	17.00
18.00	Private Duty Nursing	0	0	0	0	0	18.00
19.00	Clinic	0	0	0	0	0	19.00
20.00	Health Promotion Activities	0	0	0	0	0	20.00
21.00	Day Care Program	0	0	0	0	0	21.00
22.00	Home Delivered Meals Program	0	0	0	0	0	22.00
23.00	Homemaker Service	0	0	0	0	0	23.00
24.00	All Others (specify)	0	0	0	0	0	24.00
25.00	Total (sum of lines 1-24)	1,009,921	0	0	136	158,615	25.00
		Total (sum of col.s. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	471,409	0	471,409	-39,200	432,209	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	295,120	0	295,120	0	295,120	6.00
7.00	Physical Therapy	270,633	0	270,633	0	270,633	7.00
8.00	Occupational Therapy	96,539	0	96,539	0	96,539	8.00
9.00	Speech Pathology	13,401	0	13,401	0	13,401	9.00
10.00	Medical Social Services	136	0	136	0	136	10.00
11.00	Home Health Aide	10,075	0	10,075	0	10,075	11.00
12.00	Supplies (see instructions)	11,359	0	11,359	0	11,359	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
15.00	Telemedicine	0	0	0	0	0	15.00
HHA NONREIMBURSABLE SERVICES							
16.00	Home Dialysis Aide Services	0	0	0	0	0	16.00
17.00	Respiratory Therapy	0	0	0	0	0	17.00
18.00	Private Duty Nursing	0	0	0	0	0	18.00
19.00	Clinic	0	0	0	0	0	19.00
20.00	Health Promotion Activities	0	0	0	0	0	20.00
21.00	Day Care Program	0	0	0	0	0	21.00
22.00	Home Delivered Meals Program	0	0	0	0	0	22.00
23.00	Homemaker Service	0	0	0	0	0	23.00
24.00	All Others (specify)	0	0	0	0	0	24.00
25.00	Total (sum of lines 1-24)	1,168,672	0	1,168,672	-39,200	1,129,472	25.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider No. : 315491	Period: 01/01/2021	Worksheet H-1
		HHA CCN: 317092	To 12/31/2021	Part I
				Date/Time Prepared: 9/7/2022 4:24 pm
			Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	432,209	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	295,120	0	0	0	6.00
7.00	Physical Therapy	270,633	0	0	0	7.00
8.00	Occupational Therapy	96,539	0	0	0	8.00
9.00	Speech Pathology	13,401	0	0	0	9.00
10.00	Medical Social Services	136	0	0	0	10.00
11.00	Home Health Aide	10,075	0	0	0	11.00
12.00	Supplies (see instructions)	11,359	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
15.00	Telemedicine	0	0	0	0	15.00
HHA NONREIMBURSABLE SERVICES						
16.00	Home Dialysis Aide Services	0	0	0	0	16.00
17.00	Respiratory Therapy	0	0	0	0	17.00
18.00	Private Duty Nursing	0	0	0	0	18.00
19.00	Clinic	0	0	0	0	19.00
20.00	Health Promotion Activities	0	0	0	0	20.00
21.00	Day Care Program	0	0	0	0	21.00
22.00	Home Delivered Meals Program	0	0	0	0	22.00
23.00	Homemaker Service	0	0	0	0	23.00
24.00	All Others (specify)	0	0	0	0	24.00
25.00	Total (sum of lines 1-24)	1,129,472	0	0	0	25.00
		Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)		
		4A.00	5.00	6.00		
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation	0				4.00
5.00	Administrative and General	432,209	432,209			5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	295,120	182,935	478,055		6.00
7.00	Physical Therapy	270,633	167,756	438,389		7.00
8.00	Occupational Therapy	96,539	59,841	156,380		8.00
9.00	Speech Pathology	13,401	8,307	21,708		9.00
10.00	Medical Social Services	136	84	220		10.00
11.00	Home Health Aide	10,075	6,245	16,320		11.00
12.00	Supplies (see instructions)	11,359	7,041	18,400		12.00
13.00	Drugs	0	0	0		13.00
14.00	DME	0	0	0		14.00
15.00	Telemedicine	0	0	0		15.00
HHA NONREIMBURSABLE SERVICES						
16.00	Home Dialysis Aide Services	0	0	0		16.00
17.00	Respiratory Therapy	0	0	0		17.00
18.00	Private Duty Nursing	0	0	0		18.00
19.00	Clinic	0	0	0		19.00
20.00	Health Promotion Activities	0	0	0		20.00
21.00	Day Care Program	0	0	0		21.00
22.00	Home Delivered Meals Program	0	0	0		22.00
23.00	Homemaker Service	0	0	0		23.00
24.00	All Others (specify)	0	0	0		24.00
25.00	Total (sum of lines 1-24)	1,129,472		1,129,472		25.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider No. : 315491	Period: From 01/01/2021	Worksheet H-1
		HHA CCN: 317092	To 12/31/2021	Part II
				Date/Time Prepared: 9/7/2022 4:24 pm
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		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-432,209	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
15.00	Tel emedicine	0	0	0	0	0	15.00
HHA NONREIMBURSABLE SERVICES							
16.00	Home Dialysis Aide Services	0	0	0	0	0	16.00
17.00	Respiratory Therapy	0	0	0	0	0	17.00
18.00	Private Duty Nursing	0	0	0	0	0	18.00
19.00	Clinic	0	0	0	0	0	19.00
20.00	Health Promotion Activities	0	0	0	0	0	20.00
21.00	Day Care Program	0	0	0	0	0	21.00
22.00	Home Delivered Meals Program	0	0	0	0	0	22.00
23.00	Homemaker Service	0	0	0	0	0	23.00
24.00	All Others (specify)	0	0	0	0	0	24.00
25.00	Total (sum of lines 1-24)	0	0	0	0	-432,209	25.00
26.00	Cost To Be Allocated	0	0	0	0	0	26.00
27.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0	27.00

		Administrative & General (ACCUM. COST)					
		5.00					

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation (see instructions)						4.00
5.00	Administrative and General	697,263					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	295,120					6.00
7.00	Physical Therapy	270,633					7.00
8.00	Occupational Therapy	96,539					8.00
9.00	Speech Pathology	13,401					9.00
10.00	Medical Social Services	136					10.00
11.00	Home Health Aide	10,075					11.00
12.00	Supplies (see instructions)	11,359					12.00
13.00	Drugs	0					13.00
14.00	DME	0					14.00
15.00	Tel emedicine	0					15.00
HHA NONREIMBURSABLE SERVICES							
16.00	Home Dialysis Aide Services	0					16.00
17.00	Respiratory Therapy	0					17.00
18.00	Private Duty Nursing	0					18.00
19.00	Clinic	0					19.00
20.00	Health Promotion Activities	0					20.00
21.00	Day Care Program	0					21.00
22.00	Home Delivered Meals Program	0					22.00
23.00	Homemaker Service	0					23.00
24.00	All Others (specify)	0					24.00
25.00	Total (sum of lines 1-24)	697,263					25.00
26.00	Cost To Be Allocated	432,209					26.00
27.00	Unit Cost Multiplier	0.619865					27.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider No. : 315491

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

Worksheet H-2 Part I

HHA CCN: 317092

Date/Time Prepared: 9/7/2022 4:24 pm

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		1.00	2.00			
1.00 Administrative and General		13,045	2,665	88,929	104,639	1.00
2.00 Skilled Nursing Care	478,055	0	0	80,964	559,019	2.00
3.00 Physical Therapy	438,389	0	0	74,246	512,635	3.00
4.00 Occupational Therapy	156,380	0	0	26,485	182,865	4.00
5.00 Speech Pathology	21,708	0	0	3,676	25,384	5.00
6.00 Medical Social Services	220	0	0	0	220	6.00
7.00 Home Health Aide	16,320	0	0	2,764	19,084	7.00
8.00 Supplies	18,400	0	0	0	18,400	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Telemedicine	0	0	0	0	0	11.00
12.00 Home Dialysis Aide Services	0	0	0	0	0	12.00
13.00 Respiratory Therapy	0	0	0	0	0	13.00
14.00 Private Duty Nursing	0	0	0	0	0	14.00
15.00 Clinic	0	0	0	0	0	15.00
16.00 Health Promotion Activities	0	0	0	0	0	16.00
17.00 Day Care Program	0	0	0	0	0	17.00
18.00 Home Delivered Meals Program	0	0	0	0	0	18.00
19.00 Homemaker Service	0	0	0	0	0	19.00
20.00 All Others (specify)	0	0	0	0	0	20.00
21.00 Total (sum of lines 1-20) (2)	1,129,472	13,045	2,665	277,064	1,422,246	21.00
22.00 Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21 minus column 18, line 1, rounded to 6 decimal places.					0.000000	22.00

(1) Column 0, line 21 must agree with Wkst. A, column 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

Cost Center Description	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
1.00 Administrative and General	6,161	2,288	0	0	0	1.00
2.00 Skilled Nursing Care	32,913	0	0	0	0	2.00
3.00 Physical Therapy	30,181	0	0	0	0	3.00
4.00 Occupational Therapy	10,766	0	0	0	0	4.00
5.00 Speech Pathology	1,494	0	0	0	0	5.00
6.00 Medical Social Services	13	0	0	0	0	6.00
7.00 Home Health Aide	1,124	0	0	0	0	7.00
8.00 Supplies	1,083	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Telemedicine	0	0	0	0	0	11.00
12.00 Home Dialysis Aide Services	0	0	0	0	0	12.00
13.00 Respiratory Therapy	0	0	0	0	0	13.00
14.00 Private Duty Nursing	0	0	0	0	0	14.00
15.00 Clinic	0	0	0	0	0	15.00
16.00 Health Promotion Activities	0	0	0	0	0	16.00
17.00 Day Care Program	0	0	0	0	0	17.00
18.00 Home Delivered Meals Program	0	0	0	0	0	18.00
19.00 Homemaker Service	0	0	0	0	0	19.00
20.00 All Others (specify)	0	0	0	0	0	20.00
21.00 Total (sum of lines 1-20) (2)	83,735	2,288	0	0	0	21.00
22.00 Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21 minus column 18, line 1, rounded to 6 decimal places.						22.00

(1) Column 0, line 21 must agree with Wkst. A, column 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9.00	10.00	11.00	12.00	13.00	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider No. : 315491

Period:

Worksheet H-2

HHA CCN: 317092

From 01/01/2021
To 12/31/2021

Part I
Date/Time Prepared:
9/7/2022 4:24 pm

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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
8.00	Supplies	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Telemedicine	0	0	0	0	0	11.00
12.00	Home Dialysis Aide Services	0	0	0	0	0	12.00
13.00	Respiratory Therapy	0	0	0	0	0	13.00
14.00	Private Duty Nursing	0	0	0	0	0	14.00
15.00	Clinic	0	0	0	0	0	15.00
16.00	Health Promotion Activities	0	0	0	0	0	16.00
17.00	Day Care Program	0	0	0	0	0	17.00
18.00	Home Delivered Meals Program	0	0	0	0	0	18.00
19.00	Homemaker Service	0	0	0	0	0	19.00
20.00	All Others (specify)	0	0	0	0	0	20.00
21.00	Total (sum of lines 1-20) (2)	0	0	0	0	0	21.00
22.00	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21 minus column 18, line 1, rounded to 6 decimal places.						22.00

(1) Column 0, line 21 must agree with Wkst. A, column 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

Cost Center Description		NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE S	Subtotal (sum of cols. 3A - 15)	Post Stepdown Adjustments	Subtotal (col s. 16 ± 17)	
			15.00				
1.00	Administrative and General	0	0	113,088	0	113,088	1.00
2.00	Skilled Nursing Care	0	0	591,932	0	591,932	2.00
3.00	Physical Therapy	0	0	542,816	0	542,816	3.00
4.00	Occupational Therapy	0	0	193,631	0	193,631	4.00
5.00	Speech Pathology	0	0	26,878	0	26,878	5.00
6.00	Medical Social Services	0	0	233	0	233	6.00
7.00	Home Health Aide	0	0	20,208	0	20,208	7.00
8.00	Supplies	0	0	19,483	0	19,483	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Telemedicine	0	0	0	0	0	11.00
12.00	Home Dialysis Aide Services	0	0	0	0	0	12.00
13.00	Respiratory Therapy	0	0	0	0	0	13.00
14.00	Private Duty Nursing	0	0	0	0	0	14.00
15.00	Clinic	0	0	0	0	0	15.00
16.00	Health Promotion Activities	0	0	0	0	0	16.00
17.00	Day Care Program	0	0	0	0	0	17.00
18.00	Home Delivered Meals Program	0	0	0	0	0	18.00
19.00	Homemaker Service	0	0	0	0	0	19.00
20.00	All Others (specify)	0	0	0	0	0	20.00
21.00	Total (sum of lines 1-20) (2)	0	0	1,508,269	0	1,508,269	21.00
22.00	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21 minus column 18, line 1, rounded to 6 decimal places.						22.00

(1) Column 0, line 21 must agree with Wkst. A, column 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs	
		19.00	20.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	47,980	639,912	2.00
3.00	Physical Therapy	43,998	586,814	3.00
4.00	Occupational Therapy	15,695	209,326	4.00
5.00	Speech Pathology	2,179	29,057	5.00
6.00	Medical Social Services	19	252	6.00
7.00	Home Health Aide	1,638	21,846	7.00
8.00	Supplies	1,579	21,062	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Telemedicine	0	0	11.00
12.00	Home Dialysis Aide Services	0	0	12.00
13.00	Respiratory Therapy	0	0	13.00
14.00	Private Duty Nursing	0	0	14.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider No. : 315491	Period: From 01/01/2021	Worksheet H-2 Part I
		HHA CCN: 317092	To 12/31/2021	Date/Time Prepared: 9/7/2022 4:24 pm
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Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs	
		19.00	20.00	
15.00	Clinic	0	0	15.00
16.00	Health Promotion Activities	0	0	16.00
17.00	Day Care Program	0	0	17.00
18.00	Home Delivered Meals Program	0	0	18.00
19.00	Homemaker Service	0	0	19.00
20.00	All Others (specify)	0	0	20.00
21.00	Total (sum of lines 1-20) (2)	113,088	1,508,269	21.00
22.00	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21 minus column 18, line 1, rounded to 6 decimal places.	0.081056		22.00

- (1) Column 0, line 21 must agree with Wkst. A, column 7, line 70.
- (2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider No. : 315491 HHA CCN: 317092		Period: From 01/01/2021 To 12/31/2021		Worksheet H-2 Part II Date/Time Prepared: 9/7/2022 4:24 pm		
				Home Health Agency I		PPS		
Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
		1.00	2.00	3.00				
1.00	Administrative and General	1,238	1,238	324,153	0	104,639	1.00	
2.00	Skilled Nursing Care	0	0	295,120	0	559,019	2.00	
3.00	Physical Therapy	0	0	270,633	0	512,635	3.00	
4.00	Occupational Therapy	0	0	96,539	0	182,865	4.00	
5.00	Speech Pathology	0	0	13,401	0	25,384	5.00	
6.00	Medical Social Services	0	0	0	0	220	6.00	
7.00	Home Health Aide	0	0	10,075	0	19,084	7.00	
8.00	Supplies (see instructions)	0	0	0	0	18,400	8.00	
9.00	Drugs	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	10.00	
11.00	Telemedicine	0	0	0	0	0	11.00	
12.00	Home Dialysis Aide Services	0	0	0	0	0	12.00	
13.00	Respiratory Therapy	0	0	0	0	0	13.00	
14.00	Private Duty Nursing	0	0	0	0	0	14.00	
15.00	Clinic	0	0	0	0	0	15.00	
16.00	Health Promotion Activities	0	0	0	0	0	16.00	
17.00	Day Care Program	0	0	0	0	0	17.00	
18.00	Home Delivered Meals Program	0	0	0	0	0	18.00	
19.00	Homemaker Service	0	0	0	0	0	19.00	
20.00	All Others (specify)	0	0	0	0	0	20.00	
21.00	Total (sum of lines 1-20)	1,238	1,238	1,009,921		1,422,246	21.00	
22.00	Total cost to be allocated	13,045	2,665	277,064		83,735	22.00	
23.00	Unit cost multiplier	10.537157	2.152666	0.274342		0.058875	23.00	
Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)		
		5.00	6.00	7.00	8.00	9.00		
		1.00	Administrative and General	1,238	0	0	0	0
2.00	Skilled Nursing Care	0	0	0	0	0	2.00	
3.00	Physical Therapy	0	0	0	0	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	10.00	
11.00	Telemedicine	0	0	0	0	0	11.00	
12.00	Home Dialysis Aide Services	0	0	0	0	0	12.00	
13.00	Respiratory Therapy	0	0	0	0	0	13.00	
14.00	Private Duty Nursing	0	0	0	0	0	14.00	
15.00	Clinic	0	0	0	0	0	15.00	
16.00	Health Promotion Activities	0	0	0	0	0	16.00	
17.00	Day Care Program	0	0	0	0	0	17.00	
18.00	Home Delivered Meals Program	0	0	0	0	0	18.00	
19.00	Homemaker Service	0	0	0	0	0	19.00	
20.00	All Others (specify)	0	0	0	0	0	20.00	
21.00	Total (sum of lines 1-20)	1,238	0	0	0	0	21.00	
22.00	Total cost to be allocated	2,288	0	0	0	0	22.00	
23.00	Unit cost multiplier	1.848142	0.000000	0.000000	0.000000	0.000000	23.00	
Cost Center Description		CENTRAL SERVICES & SUPPLY (TOTAL PATIENT DAYS)	PHARMACY (TOTAL PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (TOTAL PATIENT DAYS)		
		10.00	11.00	12.00	13.00	14.00		
		1.00	Administrative and General	0	0	0	0	0
2.00	Skilled Nursing Care	0	0	0	0	0	2.00	
3.00	Physical Therapy	0	0	0	0	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	10.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider No. : 315491 HHA CCN: 317092	Period: From 01/01/2021 To 12/31/2021	Worksheet H-2 Part II Date/Time Prepared: 9/7/2022 4:24 pm
		Home Health Agency I	PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (TOTAL PATIENT DAYS)	PHARMACY (TOTAL PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (TOTAL PATIENT DAYS)	
		10.00	11.00	12.00	13.00	14.00	
11.00	Telemedicine	0	0	0	0	0	11.00
12.00	Home Dialysis Aide Services	0	0	0	0	0	12.00
13.00	Respiratory Therapy	0	0	0	0	0	13.00
14.00	Private Duty Nursing	0	0	0	0	0	14.00
15.00	Clinic	0	0	0	0	0	15.00
16.00	Health Promotion Activities	0	0	0	0	0	16.00
17.00	Day Care Program	0	0	0	0	0	17.00
18.00	Home Delivered Meals Program	0	0	0	0	0	18.00
19.00	Homemaker Service	0	0	0	0	0	19.00
20.00	All Others (specify)	0	0	0	0	0	20.00
21.00	Total (sum of lines 1-20)	0	0	0	0	0	21.00
22.00	Total cost to be allocated	0	0	0	0	0	22.00
23.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	23.00

Cost Center Description		OTHER GENERAL SERVICES (PATIENT DAYS)	
		15.00	
1.00	Administrative and General	0	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Telemedicine	0	11.00
12.00	Home Dialysis Aide Services	0	12.00
13.00	Respiratory Therapy	0	13.00
14.00	Private Duty Nursing	0	14.00
15.00	Clinic	0	15.00
16.00	Health Promotion Activities	0	16.00
17.00	Day Care Program	0	17.00
18.00	Home Delivered Meals Program	0	18.00
19.00	Homemaker Service	0	19.00
20.00	All Others (specify)	0	20.00
21.00	Total (sum of lines 1-20)	0	21.00
22.00	Total cost to be allocated	0	22.00
23.00	Unit cost multiplier	0.000000	23.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider No. : 315491 HHA CCN: 317092		Period: From 01/01/2021 To 12/31/2021		Worksheet H-3 Parts I-II Date/Time Prepared: 9/7/2022 4:24 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 20, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	639,912		639,912	2,915	1.00
2.00	Physical Therapy	3.00	586,814	0	586,814	2,573	2.00
3.00	Occupational Therapy	4.00	209,326	0	209,326	928	3.00
4.00	Speech Pathology	5.00	29,057	0	29,057	205	4.00
5.00	Medical Social Services	6.00	252		252	3	5.00
6.00	Home Health Aide	7.00	21,846		21,846	443	6.00
7.00	Total (sum of lines 1-6)		1,487,207	0	1,487,207	7,067	7.00
Program Visits							
		Part A		Part B			
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Patient Services by CBSA							
8.00	Skilled Nursing Care		35084	0	1,948		8.00
9.00	Physical Therapy		35084	0	1,670		9.00
10.00	Occupational Therapy		35084	0	612		10.00
11.00	Speech Pathology		35084	0	149		11.00
12.00	Medical Social Services		35084	0	3		12.00
13.00	Home Health Aide		35084	0	340		13.00
14.00	Total (sum of lines 8-13)			0	4,722		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 20, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	21,062	0	21,062	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description		From Wkst. C, Part I, col. 3, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED SKILLED NURSING FACILITY DEPARTMENTS							
1.00	Physical Therapy		44.00	0.604343	0	0	1.00
2.00	Occupational Therapy		45.00	0.620845	0	0	2.00
3.00	Speech Pathology		46.00	0.953106	0	0	3.00
4.00	Cost of Medical Supplies		48.00	32.649925	0	0	4.00
5.00	Cost of Drugs		49.00	1.180492	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider No. : 315491 HHA CCN: 317092		Period: From 01/01/2021 To 12/31/2021		Worksheet H-3 Parts I-III Date/Time Prepared: 9/7/2022 4:24 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits				Cost of Services	
		Part A	Part B		Part A		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	5.00	6.00	7.00	8.00	9.00		
PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	219.52	0	1,948	0	1.00	
2.00	Physical Therapy	228.07	0	1,670	0	2.00	
3.00	Occupational Therapy	225.57	0	612	0	3.00	
4.00	Speech Pathology	141.74	0	149	0	4.00	
5.00	Medical Social Services	84.00	0	3	0	5.00	
6.00	Home Health Aide	49.31	0	340	0	6.00	
7.00	Total (sum of lines 1-6)		0	4,722	0	7.00	
Cost Center Description							
		5.00	6.00	7.00	8.00	9.00	
Patient Services by CBSA							
8.00	Skilled Nursing Care					8.00	
9.00	Physical Therapy					9.00	
10.00	Occupational Therapy					10.00	
11.00	Speech Pathology					11.00	
12.00	Medical Social Services					12.00	
13.00	Home Health Aide					13.00	
14.00	Total (sum of lines 8-13)					14.00	
Program Covered Charges							
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B		Part A		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
			5.00	6.00	7.00	8.00	9.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0.000000				15.00	
16.00	Cost of Drugs	0.000000		0	0	16.00	
Cost Center Description							
		Transfer to Part I as Indicated					
		4.00					
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED SKILLED NURSING FACILITY DEPARTMENTS							
1.00	Physical Therapy	col. 2, line 2.00				1.00	
2.00	Occupational Therapy	col. 2, line 3.00				2.00	
3.00	Speech Pathology	col. 2, line 4.00				3.00	
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00	
5.00	Cost of Drugs	col. 2, line 16.00				5.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider No. : 315491 HHA CCN: 317092		Period: From 01/01/2021 To 12/31/2021		Worksheet H-3 Parts I-II Date/Time Prepared: 9/7/2022 4:24 pm	
				Title XVIII		Home Health Agency I	
Cost Center Description		Cost of Services		Total Program Cost (sum of col.s. 9-10)			
		Part B					
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance				
		10.00	11.00	12.00			
PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	427,625		427,625			1.00
2.00	Physical Therapy	380,877		380,877			2.00
3.00	Occupational Therapy	138,049		138,049			3.00
4.00	Speech Pathology	21,119		21,119			4.00
5.00	Medical Social Services	252		252			5.00
6.00	Home Health Aide	16,765		16,765			6.00
7.00	Total (sum of lines 1-6)	984,687		984,687			7.00
Cost Center Description		10.00	11.00	12.00			
Patient Services by CBSA							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost Center Description		Cost of Services					
		Part B					
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance				
		10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs	0	0				16.00

CALCULATION OF SNF-BASED HHA REIMBURSEMENT SETTLEMENT		Provider No. : 315491	Period: From 01/01/2021 To 12/31/2021	Worksheet H-4 Parts I-II
		HHA CCN: 317092		Date/Time Prepared: 9/7/2022 4:24 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF SNF-BASED HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	984,424
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	44,380
13.00	Total PPS Reimbursement - LUPA Episodes		0	30,323
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	10,800
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,069,927
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	1,069,927
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	1,069,927
27.00	Allowable bad debts (from your records)		0	0
28.00	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,069,927
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Demonstration payment adjustment amount before sequestration		0	0
30.55	Demonstration payment adjustment amount after sequestration		0	0
30.75	Sequestration for non-claims based amounts (see instructions)		0	0
30.99	Sequestration amount (see instructions)		0	0
31.00	Subtotal (see instructions)		0	1,069,927
32.00	Interim payments (see instructions)		0	1,069,927
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (see instructions)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0

ANALYSIS OF PAYMENTS TO SNF-BASED HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider No. : 315491

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

Worksheet H-5

HHA CCN: 317092

Date/Time Prepared:
9/7/2022 4:24 pm

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,069,927	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, write "NONE" or enter a 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			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			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. H-4, Part II, column as appropriate, line 32)		0		1,069,927	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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. (see instructions)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,069,927	7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor	Novitas Solutions		12001		8.00