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).

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

FORM APPROVED

OMB NO. 0938-0463

Expires: 12/31/2021

Worksheet S

Parts I, II & III

12/31/2021 Date/Time Prepared:

				5/19.	/2022 12:59 pm
PART I - COST I	REPORT STATUS				
Provi der	1. [X] Electronically prepared cost rep	ort		Date: 5/19/2022	Time: 12:59 pm
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report ent	er the number	of times the provide	r resubmitted this cos	t report
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or	leave blank for no.		
Contractor	4. [1] Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN	
	(2) Settled without audit	8.[N] Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:	•		
	(4) Reopened	10.[0]If Ii	ne 4, column 1 is "4"	 : Enter number of time	s reopened
	(5) Amended	11.Contracto	r Vendor Code	4	
	5. Date Received:	12.[F] Medi	care Utilization. Ente	r "F" for full, "L" fo	or 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 EAGLEVIEW HEALTH & REHAB (315014) 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Rob	ert Conner	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Robert Conner			2
3	Signatory Title	CF0			3
4	Date	05/19/2022 12: 59: 20 PM			4

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1. 00	2.00	3. 00	4. 00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	13, 824	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		4. 00
5. 00 SNF - BASED RHC I	0		0		5. 00
6.00 SNF - BASED FQHC I	0		0		6. 00
7.00 SNF - BASED CMHC I	0		0		7. 00
7. 10 SNF - BASED CORF I	0		0		7. 10
100. 00 TOTAL	0	13, 824	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.

Health Financial Systems EAGLEVIEW HEALTH & REHAB In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315014 Peri od: Worksheet S-2 From 01/01/2021 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2021 5/19/2022 12:59 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 849 BIG OAK ROAD PO Box: 1.00 2.00 City: PITTSGROVE State: NJ Zi p Code: 08318 2.00 3.00 County: SALEM CBSA Code: 48864 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF EAGLEVIEW HEALTH & 315014 01/01/1967 N Р Ν 4.00 REHAB 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 14. 00 15.00 Type of Control (See Instructions) 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 N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 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. Ν 19.00 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 125 191 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 125, 191 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) 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 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 N 34.00 SNF-Based FQHC N 34 00 35.00 SNF-Based CMHC Ν 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 Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 148, 750 0 0

Heal th	Financial Systems	EAGLEVIEW HEALTH	& REHAB		In Lie	u of Form CMS-	2540-10
SKI LLE	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315014 Period:						
COMPLE	X INDENTIFICATION DATA				om 01/01/2021	Part I	
				То	12/31/2021	Date/Time Pre 5/19/2022 12:	
						Y/N	J9 pili
						.,	-
10.00						1.00	10.00
42.00	Are malpractice premiums and paid loss					N	42. 00
	center? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listing	g cost cen [.]	ters and		
	amounts.						
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Ch	apter 10?			Υ	43.00
44.00	If line 43 is yes, enter the home offi	ce chain number and enter	the name and ad	dress of	the home	HB2128	44.00
	office on lines 45, 46 and 47.						
	1.00	2. 00			3. 00		
	If this facility is part of a chain or	ganization, enter the nam	ne and address of	f the home	office on the	lines	
	bel ow.						
45.00	Name: AMERICAN HEALTH CORPORATION	Contractor's Name: NOVITA	AS SOLUTIONS C	Contractor'	s Number: 1250	1	45. 00
46.00	Street: 200 BARR HARBOR RIVE	PO Box:					46. 00
	City: WESTCONSHOHOCKEN	State: PA	7	ip Code:	1942	8	47. 00
00	13	1	ļ-		.,.=	-	1 00

Heal th	Financial Systems	EAGLEVIEW HEALTH	& REHAB		In Li€	eu of Form CMS-	-2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE				Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II	2 epared:
					Y/N	Date	. 57 piii
	General Instruction: For all column 1 respons	ses enter in column	1 "V" fo	r Ves or "N"	1.00	2. 00	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in corumn	1, 1 10	i les oi ii	TOT NO. TOT ATT	the date	
1. 00	Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter 1 instructions)				N		1.00
				Y/N	Date 2.00	V/I	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.			1. 00 N	2.00	3.00	2. 00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or firelationships? (see instructions)	., chain home offic d to the provider o l, or members of th	es, drug r its e board	Y			3.00
				Y/N	Туре	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A" Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	' for Audited, "C" te copy or enter da	for te	N			4.00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If creconciliation.	revenues different	from	N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
6. 00 7. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instru	ctions.	•	N N	N	7. 00
8. 00	Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) se		ng period	ror nursing	N	Y/N 1.00	8. 00
	Bad Debts					1.00	
9. 00 10. 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.	t collection policy	change du	ring this cos		Y N	9. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wa	ived? If "	Y", see instr	ucti ons.	N N	11. 00
12. 00	Have total beds available changed from prior	cost reporting per	iod? If "Y		_	N	12.00
		Descriptio	n	Y/N	rt A Date	Part B Y/N	
		0		1. 00	2. 00	3. 00	
13. 00	PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			N		N	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			Y	04/25/2022	Y	14. 00
15. 00	4. 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

Heal th	Financial Systems	EAGLEVIEW HEALTI	H & REHAB		In Lie	u of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY X REIMBURSEMENT QUESTIONNAIRE	/ HEALTH CARE	Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/19/2022 12:	pared:
			1.	00	2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/		BERT		CONNER		19. 00
	held by the cost report preparer in columns 1, respectively.	2, and 3,					
20. 00	Enter the employer/company name of the cost repreparer.	port AM	ERICAN HEALT	H CORPORATION			20. 00
21. 00	Enter the telephone number and email address o report preparer in columns 1 and 2, respective		0-890-8977		BOB@AMERI CANHEA N. NET	ALTHCORPORATI O	21. 00

Health Financial Systems	EAGLEVIEW HEALTH &	& REHAB	In Lie	u of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLE	D NURSING FACILITY HEALTH CARE	Provider No.: 315014	Peri od:	Worksheet S-2
COMDLEY DELMDIDSEMENT OLIESTIONNALDE			From 01/01/2021	Part II

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2021	
		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.)				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.	04/02/2022			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
	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 held by the cost report preparer in columns 1 respectively.		CF0		19. 00
20. 00	Enter the employer/company name of the cost r	report			20. 00
21. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respective				21. 00

Health Financial Systems EAGLEVIEW HEALTH & REHAB In Lieu of Form CMS-2540-10 Provi der No.: 315014

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

Peri od: Worksheet S-3 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021

5/19/2022 12:59 pm Inpatient Days/Visits Title XVIII Component Number of Beds Bed Days Title V Title XIX Avai I abl e 1.00 4.00 5.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 84 30, 660 3, 023 15, 891 1. 00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 7.00 Λ 7.00 8.00 Total (Sum of lines 1-7) 30, 660 3,023 15, 891 8.00 Inpatient Days/Visits Di scharges Component 0ther Total Title V Title XVIII Title XIX 6.00 8.00 9. 00 10.00 SKILLED NURSING FACILITY 1.00 4,520 68 35 1.00 23, 434 NURSING FACILITY 2.00 2 00 0 0 3.00 ICF/IID 0 3.00 4.00 HOME HEALTH AGENCY COST 0 4.00 Other Long Term Care SNF-Based CMHC 0 5.00 5.00 6.00 6 00 6.10 SNF-Based CORF 6.10 HOSPI CE 7.00 7.00 Total (Sum of lines 1-7) 35 8.00 4.520 8.00 23. 434 68 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 11. 00 13.00 14.00 15.00 12.00 1.00 SKILLED NURSING FACILITY 145 0. 00 454.03 1.00 42 44.46 2.00 NURSING FACILITY 0 0.00 0.00 2.00 ICF/IID 0 3.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 0.00 0.00 7 00 0 00 7 00 Total (Sum of lines 1-7) 454.03 8.00 42 145 0.00 44.46 8.00 Average Length Admi ssi ons of Stay Component Title V Title XVIII 0ther Title XIX Total 19.00 20.00 16.00 17.00 18.00 1.00 SKILLED NURSING FACILITY 161. 61 72 22 53 1.00 2.00 NURSING FACILITY 0.00 0 0 2.00 ICF/IID 3.00 0.00 0 3.00 0 HOME HEALTH AGENCY COST 4 00 4 00 5.00 Other Long Term Care 0.00 5.00 6.00 SNF-Based CMHC 6.00 6.10 SNF-Based CORF 6.10 7.00 HOSPI CE 0.00 Γ 0 7.00 Total (Sum of lines 1-7) 8.00 161.61 72 22 53 8.00 Admi ssi ons Full Time Equivalent Component Total Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 147 75. 62 0.00 1. 00 NURSING FACILITY 0.00 0.00 2.00 2.00 0 3.00 LCF/LLD 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0.00 0.00 5.00 SNF-Based CMHC 0.00 0.00 6.00 6.00 6.10 SNF-Based CORF 0.00 0.00 6. 10

0.00

75.62

147

0.00

0.00

7.00

8.00

HOSPI CE

Total (Sum of lines 1-7)

7.00

8.00

					o 12/31/2021		
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
		Ropor tou	Worksheet A-6	1 ± col . 2)	Salary in col.	col . 4)	
			WOT KSTICCE AT C	1 1 001. 2)	3	601. 1)	
		1.00	2.00	3.00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	3, 333, 624	0	3, 333, 624	157, 290. 87	21. 19	1.00
2.00	Physician salaries-Part A	0	0	(0.00		2. 00
3.00	Physician salaries-Part B	0	0	(0.00	0.00	3. 00
4.00	Home office personnel	0	0	(0.00		4. 00
5.00	Sum of lines 2 through 4	0	0	(0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	3, 333, 624	0	3, 333, 624	157, 290. 87	21. 19	6.00
7.00	Other Long Term Care	0	0	(0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	(0.00	0.00	8. 00
9.00	CMHC	0	0	(0.00	0.00	9. 00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	(0.00	0.00	10.00
11. 00	Other excluded areas	0	0	(0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	(0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	3, 333, 624	0	3, 333, 624	157, 290. 87	21. 19	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
	Contract Labor: Patient Related & Mgmt	38, 932	0	38, 932			14. 00
	Contract Labor: Physician services-Part A	0	0	1	0.00		15. 00
16. 00	Home office salaries & wage related costs	0	0	(0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	,	639, 253	0	639, 253	3		17. 00
18. 00	,	0	0	()		18. 00
19. 00		0	0	()		19. 00
20.00	Physician Part A - WRC	0	0	()		20.00
21. 00	Physician Part B - WRC	0	0	()		21.00
22. 00	Total Adjusted Wage Related cost (see	639, 253	0	639, 253	3		22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION EAGLEVIEW HEALTH & REHAB

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: | To 12/31/202 Provi der No.: 315014

				'	0 12/31/2021	5/19/2022 12:	
	·	Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	() C	0.00	0.00	1. 00
2.00	Administrative & General	393, 170	(393, 170	15, 204. 38	25. 86	2. 00
3.00	Plant Operation, Maintenance & Repairs	92, 577	(92, 577	3, 988. 60	23. 21	3. 00
4.00	Laundry & Linen Service	37, 329	· C	37, 329	3, 065. 14	12. 18	4. 00
5.00	Housekeepi ng	128, 612	(128, 612	9, 385. 39	13. 70	5. 00
6.00	Di etary	273, 215	(273, 215	18, 048. 69	15. 14	6. 00
7.00	Nursing Administration	262, 958	C	262, 958	6, 179. 57	42. 55	7. 00
8.00	Central Services and Supply	34, 420	(34, 420	2, 086. 46	16. 50	8. 00
9.00	Pharmacy	0	() C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	() C	0.00	0.00	10. 00
11. 00	Soci al Servi ce	58, 792	(58, 792	2, 070. 41	28. 40	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	69, 484	0	69, 484	4, 009. 47	17. 33	13. 00
14. 00	Total (sum lines 1 thru 13)	1, 350, 557	c	1, 350, 557	64, 038. 11	21. 09	14. 00

Health Financial Systems	EAGLEVIEW HEALTH & REHAB	In Lie	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315014	From 01/01/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/19/2022 12:59 pm

	To 12/31/2021		
		Amount Reported	·
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Shel tered Annui ty (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
1. 00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	Ŭ	1. 00
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
7.00	HEALTH AND INSURANCE COST	0	7.00
8. 00	Heal th Insurance (Purchased or Self Funded)	171, 412	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
		0	12.00
13. 00			13. 00
		0	14. 00
15. 00	Workers' Compensation Insurance	228, 233	
16. 00		220, 233	16. 00
10.00	Non cumulative portion)		10.00
	TAXES		
17 00	FICA-Employers Portion Only	192, 001	17 00
18. 00		35, 721	
	Unemployment Insurance	0	19. 00
	State or Federal Unemployment Taxes	48, 688	
20.00	OTHER	40, 000	20.00
21 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances		22. 00
	Tuition Reimbursement		23. 00
	Total Wage Related cost (Sum of lines 1 - 23)	676, 055	
24.00	Trotal mage norated cost (our of fines i - 25)	Amount	24.00
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
_0.00	1	١	_0.00

	<u> 19/2022 12: 5</u> 9	
Occupational Category Amount Fringe Adjusted Paid Hours Avera	rage Hourly	<i>y</i> piii
	e (col. 3 ÷	
	col . 4)	
3	,	
1.00 2.00 3.00 4.00	5. 00	
Direct Salaries		
Nursing Occupations		
1.00 Registered Nurses (RNs) 200, 228 16, 624 216, 852 6, 195.00	35. 00	1. 00
2.00 Licensed Practical Nurses (LPNs) 814,421 67,619 882,040 30,055.30	29. 35	2.00
3.00 Certified Nursing 485 418 80,405 1,048,823 57,002.46	18. 40	3.00
Assi stants/Ai des		
4.00 Total Nursing (sum of lines 1 through 3) 1,983,067 164,648 2,147,715 93,252.76	23. 03	4. 00
5. 00 Physi cal Therapi sts 0 0 0 0.00	0.00	5. 00
6.00 Physical Therapy Assistants 0 0 0 0.00	0.00	6. 00
7.00 Physical Therapy Aides 0 0 0.00	0.00	7. 00
8.00 Occupational Therapists 0 0 0 0.00	0. 00	8. 00
9.00 Occupational Therapy Assistants 0 0 0 0.00	0. 00	9. 00
10.00 Occupational Therapy Aides 0 0 0 0.00		10.00
11.00 Speech Therapists 0 0 0 0.00		11. 00
12. 00 Respiratory Therapists 0 0 0 0.00		12.00
13.00 Other Medical Staff 0 0 0 0.00	0. 00	13. 00
Contract Labor		
Nursing Occupations	0.00	14 00
14. 00 Registered Nurses (RNs) 0 0 0.00 15. 00 Licensed Practical Nurses (LPNs) 0 0 0.00		14.00
		15.00
16.00 Certified Nursing Assistant/Nursing 0 0 0.00	0. 00	16. 00
17.00 Total Nursing (sum of lines 14 through 16) 0 0.00	0.00	17. 00
18. 00 Physical Therapists 154, 032 154, 032 2, 232. 34		18. 00
19. 00 Physical Therapy Assistants 0 0 0. 00		19. 00
20. 00 Physical Therapy Aides 0 0 0.00		20. 00
21. 00 Occupational Therapists 143,501 143,501 2,079.72		21. 00
22. 00 Occupational Therapy Assistants 0 0 0.00		22. 00
23. 00 Occupational Therapy Aides 0 0 0.00		23. 00
24. 00 Speech Therapists 128,693 128,693 1,865 12		24. 00
25. 00 Respiratory Therapists 0 0 0.00		25. 00
26. 00 Other Medical Staff 0 0 0.00		26. 00
	0.001	20.00

Peri od: Worksheet S-7
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/19/2022 12:59 pm

100 100		10 12/31/202	5/19/2022 12:59 pm
1,00			
2.00 Salid 2.00 Salid 3.00	100		
3.00 3.00			
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Description			
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7.00 BMX R.00 BMX R.00			
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10.00 Rich 11.00 Rich 11.00	8.00	RML	8.00
11.00 RUB 11			
12.00 RIA 12.00 RVG 13.00 RVG			
13.00 RVC			
14.00 RW 11.00 RW 15.00 RW 17.00 RW 17.			
15.00 RW 15.00 RW 16.00 RW 16.00 RW 16.00 RW 17.00 RW 18.00 RW 19.00 RW 19.			
16.00 RHC 17.00 SHB 17.00 SHB 17.00 SHB SHB 17.00 SHB SHB SHB 17.00 SHB			
17. 00 RHB			
19.00		RHB	
20.00 R8B 20.00 R1B 22.00 R1B			
21.00 RILB 22.00 RILB 23.00 RILB 23.0			
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67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PE2 67. 00 PP1 68. 00 PP2 69. 00 PP1 70. 00 PP1 70. 00 PP1 72. 00 PP1 72. 00 PP1 72. 00 PP1 73. 00 PP1 74. 00	65. 00	BA2	65. 00
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70. 00 71. 00 72. 00 73. 00 74. 00 PB1 70. 00 PC2 71. 00 PC1 72. 00 PB2 73. 00 PB1 74. 00			
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			74.00
			75. 00

Health Financial Systems	EAGLEVIEW HEALTH 8	& REHAB		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Date/Time Pr 5/19/2022 12	epared:
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Register V payments beginning 10/01/2003. Congress expe expenses. For lines 101 through 106: Enter i column 2 the percentage of total expenses fo line 1, column 3. Indicate in column 3 "Y" f with direct patient care and related expense (See instructions)	cted this increase to n column 1 the amour r each category to for yes or "N" for no	to be used nt of the total SNF o if the s	for direct pexpense for expense for expense from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing						101. 00
102.00 Recrui tment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105.00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne 1, column 3)					106. 00

Health Financial Systems	EAGLEVIEW HEALT	H & REHAB		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2021	D 1 (T' D	
				Го 12/31/2021	Date/Time Pre 5/19/2022 12:	pared: 50 nm
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	J / piii
cost conton boson per on	00.0	01	+ col . 2)	ons	Trial Balance	
			' ' ' ' ' ' ' '	Increase/Decre	(col. 3 +-	
				ase (Fr Wkst	col. 4)	
				A-6)		
	1.00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES		80, 396	80, 390	0	80, 396	1.00
2.00 00200 CAP REL COSTS - MOVEABLE EQUIPMENT		44, 795	44, 79!	5 0	44, 795	2.00
3.00 00300 EMPLOYEE BENEFITS	o	0		0	0	3.00
4.00 00400 ADMINISTRATIVE & GENERAL	393, 170	1, 664, 787	2, 057, 95	7 0	2, 057, 957	4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	92, 577	362, 276	454, 853	3 0	454, 853	5.00
6.00 00600 LAUNDRY & LINEN SERVICE	37, 329	29, 886	67, 21!	5 0	67, 215	6.00
7. 00 00700 HOUSEKEEPI NG	128, 612	65, 657	194, 269	9 0	194, 269	7. 00
8. 00 00800 DI ETARY	273, 215	301, 564	574, 779	9 0	574, 779	8. 00
9.00 00900 NURSING ADMINISTRATION	262, 958	851, 367	1, 114, 32	5 0	1, 114, 325	9. 00
10.00 O1000 CENTRAL SERVICES & SUPPLY	34, 420	14, 792	49, 212	2 0	49, 212	10.00
12.00 O1200 MEDICAL RECORDS & LIBRARY	0	24, 381			24, 381	12.00
13. 00 01300 SOCIAL SERVICE	58, 792	17, 043	75, 83!	5 0	75, 835	13.00
15. 00 01500 OTHER GENERAL SERVICES	69, 484	16, 814	86, 298	3 0	86, 298	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	1, 983, 067	0	1, 983, 06	7 0	1, 983, 067	30.00
31.00 03100 NURSING FACILITY	0	0)	0	0	31. 00
32. 00 03200 1CF/IID	0	0)	0	0	32.00
33.00 O3300 OTHER LONG TERM CARE	0	0)	0	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0	0)	0	0	40.00
41. 00 04100 LABORATORY	0	0)	0	0	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0	0)	0	0	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY	0	0)	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0	154, 032	154, 032	2 0	154, 032	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	143, 501			143, 501	45. 00
46.00 04600 SPEECH PATHOLOGY	0	128, 693	128, 693	0	128, 693	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	1	-	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	167, 627			167, 627	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	99, 865	99, 86!	5 0	99, 865	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 O5200 OTHER ANCILLARY SERVICES	0	0) (0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0	0	1	0	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC	0	0)	0	0	61. 00
62. 00 06200 FQHC	_	_			_	62. 00
63. 00 06300 OTHER OUTPATIENT SERVICES	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
73. 00 07300 CMHC	0	0		0	0	73. 00
74. 00 O7400 OTHER REIMBURSABLE COST	0	0) (0	0	74. 00
SPECIAL PURPOSE COST CENTERS						
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0	0	80.00
81. 00 08100 INTEREST EXPENSE		0		0	0	81.00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF	0	0		0	0	82. 00
83. 00 08300 HOSPI CE	0	0		0	0	83.00
84. 00 08400 OTHER SPECIAL PURPOSE COST	0 000 (04	0	7 504 404	0	7 504 400	84.00
89. 00 SUBTOTALS (sum of lines 1-84)	3, 333, 624	4, 167, 476	7, 501, 100	ט ט	7, 501, 100	89. 00
NONREI MBURSABLE COST CENTERS					0	00.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0			0	90. 00 91. 00
91. 00 09100 BARBER & BEAUTY SHOP		0			0	
92.00 O9200 PHYSICIANS' PRIVATE OFFICES 93.00 O9300 NONPAID WORKERS		0			0	92.00
93. 00 09300 NONPALD WORKERS 94. 00 09400 PATLENTS' LAUNDRY		0			0	93.00
95. 00 09500 OTHER NONREIMBURSABLE COST		0			0	94. 00 95. 00
100.00 TOTAL	2 222 424	/ 147 /7/	7 501 100		7, 501, 100	
100.00 101AL	3, 333, 624	4, 167, 476	7, 501, 100	ال ال	7, 501, 100	100.00

 Heal th Financial
 Systems
 EAGLEVIEW

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315014 | Period: | Worksheet A | From 01/01/2021 | To 11/31/2021 | Date/Time Pr

				To 12/31/2021 Date/Time Pro 5/19/2022 12:	epared:
	Cost Center Description	Adjustments to	Net Expenses	3/17/2022 12.	J pill
		, ,	For Allocation	ו	
		Wkst A-8)	(col. 5 +- col. 6)		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	_	1		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVEABLE EQUIPMENT	0	80, 396	1	1.00
2. 00 3. 00	00300 EMPLOYEE BENEFITS		44, 795 C		2. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL		2, 057, 957		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	454, 853	1	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	67, 215	1	6. 00
7.00	00700 HOUSEKEEPI NG	0	194, 269	1	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	0	574, 779	I and the second	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		1, 114, 325 49, 212	1	10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	24, 381	1	12. 00
13.00	01300 SOCIAL SERVICE	0	75, 835	1	13. 00
15. 00	01500 OTHER GENERAL SERVICES	0	86, 298	3	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 002 0/3	7	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	,		30. 00 31. 00
32. 00	03200 CF/11D			1	32.00
	03300 OTHER LONG TERM CARE	0		l .	33. 00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	0		1	40.00
41. 00	04100 LABORATORY	0	C		41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY				42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		154, 032		44. 00
	04500 OCCUPATI ONAL THERAPY	0	143, 501		45. 00
46.00	04600 SPEECH PATHOLOGY	0	128, 693	3	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	C		47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	167, 627	1	48. 00 49. 00
50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY		99, 865 C	I and the second	50.00
51. 00	05100 SUPPORT SURFACES			1	51.00
52.00	05200 OTHER ANCILLARY SERVICES	0	C		52. 00
	OUTPATIENT SERVICE COST CENTERS		T		
60.00	06000 CLINIC	0			60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	C	J	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICES	0	c		63.00
00.00	OTHER REIMBURSABLE COST CENTERS				30.00
	07000 HOME HEALTH AGENCY COST	0		l .	70. 00
71. 00	07100 AMBULANCE	0	C	1	71. 00
	07200 CORF	0	C	1	72.00
73. 00 74. 00	07300 CMHC 07400 OTHER REI MBURSABLE COST		C	l .	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS			5	74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	C		80.00
81. 00	08100 I NTEREST EXPENSE	0	C	D	81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	0	C		82. 00
83.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST				83. 00
84. 00 89. 00	SUBTOTALS (sum of lines 1-84)		_		84. 00 89. 00
57.00	NONREI MBURSABLE COST CENTERS		, ,, 301, 100	<u> </u>	1 57.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		90. 00
91. 00	09100 BARBER & BEAUTY SHOP	0	C		91. 00
92.00	09200 PHYSI CLANS' PRI VATE OFFI CES	0	C		92.00
93.00	09300 NONPAI D WORKERS 09400 PATI ENTS' LAUNDRY				93. 00 94. 00
	09500 OTHER NONREIMBURSABLE COST				95.00
100.00			_	1	100.00
					-

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2540-10
Worksheet A-7 EAGLEVIEW HEALTH & REHAB Provi der No.: 315014

Peri od: From 01/01/2021

				Ť	o 12/31/2021	Date/Time Prep 5/19/2022 12:5	
	·		·	Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		_	_		_	
1.00	Land	200, 000	0	(0	0	1. 00
2.00	Land Improvements	0	0	C	0	0	2. 00
3.00	Buildings and Fixtures	1, 824, 000	0	C	0	0	3. 00
4.00	Building Improvements	1, 456, 756	19, 657	(19, 657	0	4. 00
5.00	Fi xed Equipment	175, 158	0	(0	0	5. 00
6.00	Movable Equipment	647, 550	12, 785		12, 785		6.00
7.00	Subtotal (sum of lines 1-6)	4, 303, 464	32, 442	(32, 442	0	7. 00
8.00	Reconciling Items	0	0	(0	0	8. 00
9. 00	Total (line 7 minus line 8)	4, 303, 464	32, 442	C	32, 442	0	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	200, 000	0				1.00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	1, 824, 000	0				3.00
4.00	Building Improvements	1, 476, 413	0				4.00
5.00	Fixed Equipment	175, 158	0				5.00
6.00	Movable Equipment	660, 335	0				6.00
7.00	Subtotal (sum of lines 1-6)	4, 335, 906	0				7. 00
8.00	Reconciling Items	0	0				8.00
9. 00	Total (line 7 minus line 8)	4, 335, 906	0				9. 00

Worksheet A-8 From 01/01/2021 | Worksneet A-8 | To 12/31/2021 | Date/Time Prepared:

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted To/From Vhich To/From					10 12/31/2021	5/19/2022 12:	
Description (1)					Expense Classification on		J 7 DIII
Description (1)							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00					TO/TTOIL WITCH THE AMOUNT TS	to be Aujusteu	
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00							
1.00 Investment income on restricted funds (chapter 2) 2.00 3.00 4.00		D (4)	(0) D : E			T 11 N	
1.00 Investment income on restricted funds (chapter 2) 0 0 0 0 0 0 0 0 0		Description (1)	` '	Amount	Cost Center	Line No.	
1.00 Investment Income on restricted funds (chapter 2) Trade, quantity, and time discounts (chapter 8) 0 0.00 2.00 3.00 8 0 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 4.00 8 0.00 6 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00				0.00		1.00	
Chapter 2)		I	1.00				
Trade, quantity, and time discounts (chapter 8) 0 0 0 0 0 0 0 0 0	1.00			0)	0.00	1. 00
8)				_			
3.00 Refunds and rebates of expenses (chapter 8) 0 0.00 3.00 3.00 4.00 5.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 1.00 1.00 5.00 1.00 1.00 5.00 1.00	2.00			0)	0.00	2.00
A. 00 Rental of provider space by suppliers 0 0 0 4.00							
Chapter 8 Chapter 8 0				0)		
5.00 Telephone services (pay stations excluded) (chapter 21) 0 0.00 5.00	4.00	Rental of provider space by suppliers		0		0.00	4. 00
Chapter 21)							
Color Television and radio service (chapter 21) 0 0.00 6.00 7.00 8.00	5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
7.00		(chapter 21)					
8.00 Remuneration applicable to provider-based physician adjustment 0	6.00	Television and radio service (chapter 21)		0		0.00	6. 00
physician adjustment	7.00	Parking Lot (chapter 21)		0		0.00	7. 00
9.00 Home office cost (chapter 21) 0 0.00 9.00 0.00 10.00 11.00	8.00	Remuneration applicable to provider-based	A-8-2	0)		8. 00
10.00 Sale of Scrap, waste, etc. (chapter 23) 0.00 10.		physician adjustment					
10.00 Sale of Scrap, waste, etc. (chapter 23) 0.00 10.	9.00	Home office cost (chapter 21)		0		0.00	9. 00
11.00	10.00	Sale of scrap, waste, etc. (chapter 23)		d		0.00	10.00
Capit all expenditures (chapter 24) Adjustment resulting from transactions with real ated organizations (chapter 10) 12.00 13.00 14.00 Revenue - Employee meals 0	11. 00			ĺ		0.00	11.00
12. 00							
related organizations (chapter 10) 13. 00 Laundry and Linen service 14. 00 Revenue - Employee meals 15. 00 Cost of meals - Guests 16. 00 Sale of medical supplies to other than patients 17. 00 Sale of drugs to other than patients 18. 00 Sale of drugs to other than patients 19. 00 Vending machines 19. 00 Vending machines 10 Income from imposition of interest, finance or penalty charges (chapter 21) 21. 00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22. 00 Utilization reviewphysicians' compensation (chapter 21) 23. 00 Depreciationbuildings and fixtures 24. 00 Depreciationmovable equipment 25. 00 Other adjustment (specify) 100. 00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)	12.00		A-8-1	Ó			12. 00
13.00 Laundry and Linen service 0 0.00 13.00 14.00 Revenue - Employee meals 0 0.00 14.00 15.00 Cost of meals - Guests 0 0.00 15.00 16.00 Sale of medical supplies to other than patients 0 0.00 16.00 17.00 Sale of drugs to other than patients 0 0.00 17.00 18.00 Sale of medical records and abstracts 0 0.00 18.00 19.00 Vending machines 0 0.00 18.00 19.00 Lincome from imposition of interest, finance or penalty charges (chapter 21) 0.00 0.00 19.00 10.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 19.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 19.0							
14.00 Revenue - Employee meals 0 0.00 14.00 15.00 15.00 Cost of meals - Guests 0 0.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 Sale of medical supplies to other than patients 0 0.00 17.00 17.00 18.00 18.00 19.00	13. 00			Ó		0.00	13.00
15.00 Cost of meals - Guests 16.00 Sale of medical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Vending machines 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)				Ô		•	
16.00 Sale of medical supplies to other than patients 0 0 16.00 17.00 Sale of drugs to other than patients 0 0 0.00 17.00 18.00 Sale of medical records and abstracts 0 0 0.00 18.00 19.00 Vending machines 0 0 0.00 18.00 19.00 Vending machines 0 0 0.00 19.00 10.00 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0 0 0.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10		1 3		_			
17.00 Sale of drugs to other than patients 0 0.00 17.00		1		_		1	•
17. 00 Sale of drugs to other than patients Sale of medical records and abstracts 0 0 0 17. 00 18. 00 Sale of medical records and abstracts 0 0 0 0 18. 00 19. 00 Vending machines 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 19. 00 10. 00 20. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 21. 00 10. 00 22. 00 10. 00 22. 00 10. 00 23. 00 10. 00 24. 00 10. 00 25. 00 100. 00 10. 00 100. 0	10.00				1	0.00	10.00
18.00 Sale of medical records and abstracts 19.00 Vending machines 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)	17 00	1!		0		0.00	17 00
19.00 Vending machines 10.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)							
20.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)				0			
or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)						1	
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)	20.00			0	1	0.00	20.00
and borrowings to repay Medicare overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100) OUTILIZATION REVIEW - SNF 82.00 22.00 CAP REL COSTS - BLDGS & 1.00 23.00 FIXTURES OCAP REL COSTS - MOVEABLE EQUIPMENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21 00			,		0.00	21 00
overpayments 22.00 Utilization reviewphysicians' compensation (chapter 21) Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment Depreciationmovable equipment OCAP REL COSTS - BLDGS & 1.00 23.00 FIXTURES OCAP REL COSTS - MOVEABLE EQUIPMENT OCAP REL COSTS - MOVEABLE EQUIPMEN	21.00			0	1	0.00	21.00
22.00 Utilization reviewphysicians' compensation (chapter 21) 23.00 Depreciationbuildings and fixtures 24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100) 20.00 UTILIZATION REVIEW - SNF 82.00 22.00 CAP REL COSTS - BLDGS & 1.00 23.00 FIXTURES 0 CAP REL COSTS - MOVEABLE EQUIPMENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
23.00 Chapter 21) Depreciationbuildings and fixtures OCAP REL COSTS - BLDGS & 1.00 23.00 24.00 Depreciationmovable equipment OCAP REL COSTS - MOVEABLE EQUIPMENT O.00 25.00 25.00 Other adjustment (specify) Ocap REL COSTS - MOVEABLE Ocap REL COSTS - MO	22.00		4	,	UTILIZATION DEVIEW CNE	02.00	22.00
23.00 Depreciationbuildings and fixtures 0 CAP REL COSTS - BLDGS & 1.00 23.00 FIXTURES 0 CAP REL COSTS - MOVEABLE 2.00 24.00 EQUI PMENT 0 OTHER adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)	22.00			0	JUTILIZATION REVIEW - SNF	82.00	22.00
24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100) FIXTURES 0 CAP REL COSTS - MOVEABLE EQUIPMENT 0 0 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)	22 00			,	CAD DEL COSTS DIDOS	1 00	22.00
24.00 Depreciationmovable equipment 25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100) 0 CAP REL COSTS - MOVEABLE EQUI PMENT 0 0 0 0 24.00 100.00 10	∠ა. ∪∪	peprecrationpuridings and fratures				1.00	∠3.00
25.00 Other adjustment (specify) 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100) EQUIPMENT 0 0 25.00 100.00	24.00	Dennasi ati an mayahla agui nmant		,		2.00	24.00
25.00 Other adjustment (specify) 0 0.00 25.00 100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)	24.00	Depreciationmovabre equipment				2.00	∠4. UU
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)	25 22	Other adjustment (const C)		_			25 22
to Worksheet A, col. 6, line 100)				0	2	0.00	
	100.00			0) 		100.00
		•	 -	l :	1	1	l

(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.

Heal th Financial Systems EAGLEVIEW HEALT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS EAGLEVIEW HEALTH & REHAB

OFFICE COSTS				o 12/31/2021	Date/Time Pre	
	Li ne No.	Cost (Center	Expense	5/19/2022 12: e Items	59 pm
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQU CLAIMED HOME OFFICE COSTS:	IRED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR OR	
1.00	4. 00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE MG	WT FEES	1.00
2. 00		SKILLED NURSIN	G FACILITY	MEDICAL SUPPLII	ES	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 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, lir	e					
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minus			
	Cost	Wkst. A, col.	col. 5)			
		5				
	4. 00	5. 00	6. 00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQU CLAIMED HOME OFFICE COSTS:				D ORGANIZATIONS	S OR	
1.00	420, 439	420, 439)		1. 00
2. 00	14, 566	14, 566	C			2. 00
3. 00	0	0	[C			3. 00
4.00	0	0	C)		4. 00
5. 00	0	0	C)		5. 00
6. 00	0	0	C)		6. 00
7. 00	0	0	C)		7. 00
8. 00	0	0	C)		8. 00
9. 00	0	0	C)		9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column		435, 005	[C)		10. 00
6, line 100 to Worksheet A-8, column 3, lir	e					
12.						

OFFICE COSTS

Provider No.: 315014 Peri od: From 01/01/2021 12/31/2021 Worksheet A-8-1

Parts I-II Date/Time Prepared: 5/19/2022 12:59 pm Symbol (1) Name Percentage of Ownershi p 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	В	AMERICAN HEALTH	100.00	1.00
2.00	Α	FOUR SEASONS	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)			0.00	100.00
speci fy:				

- (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 rel ated 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.

	Rel ated Organi	Related Organization(s) and/or Home Office							
	Name	Percentage of Ownership	Type of Business						
DART LL LATERDE ATLANGUER TO RELATER ARRANGE	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. 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	•	AMERICAN HEALTH CORP	100.00	HEALTHCARE	1. 00
2. 00		FOUR SEASONS	0.00	MEDICAL SUPPLIE	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)		0.00		100. 00
spec	ci fy:				

- (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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315014

					То	12/31/2021	Date/Time Pre 5/19/2022 12:	pared:
				CAPI TAL REL	ATED COSTS		37 177 2022 12.	J Pill
		Cost Center Description	Net Expenses	BLDGS &	MOVEABLE	EMPLOYEE	ADMI NI STRATI VE	
		osst same. Boss. pt. o	for Cost	FIXTURES	EQUI PMENT	BENEFI TS	& GENERAL	
			Allocation (from Wkst A					
			col. 7)					
	CENED	AL CEDIUSE COST CENTEDS	0	1. 00	2. 00	3. 00	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	80, 396	80, 396				1. 00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT	44, 795	22, 213	44, 795			2. 00
3.00		EMPLOYEE BENEFITS	0	204	114	318	l e	3.00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	2, 057, 957 454, 853	13, 060 0	7, 277	0	2, 078, 294	4. 00 5. 00
6. 00	00600	LAUNDRY & LINEN SERVICE	67, 215	537	299	0	0	6. 00
7. 00 8. 00	4	HOUSEKEEPI NG DI ETARY	194, 269	685		0	0	7.00
9. 00	4	NURSING ADMINISTRATION	574, 779 1, 114, 325	11, 958 519		0	0 0	8. 00 9. 00
10.00	01000	CENTRAL SERVICES & SUPPLY	49, 212	0	0	0	0	10. 00
12.00		MEDICAL RECORDS & LIBRARY	24, 381	157		0	0	12.00
13. 00 15. 00		SOCIAL SERVICE OTHER GENERAL SERVICES	75, 835 86, 298	500 0		0	0 0	13. 00 15. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		SKILLED NURSING FACILITY NURSING FACILITY	1, 983, 067	47, 394		318		30.00
31. 00 32. 00		NURSING FACILITY ICF/IID	0	0	0	0	0 0	31. 00 32. 00
33. 00	03300	OTHER LONG TERM CARE	O	0		0	0	33. 00
40.00		LARY SERVICE COST CENTERS	0	0			0	40.00
40. 00 41. 00		RADI OLOGY LABORATORY	0	0	0	0	0	40. 00 41. 00
42. 00	04200	I NTRAVENOUS THERAPY	o	0	ō	0	0	42. 00
43.00		OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00 45. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	154, 032 143, 501	1, 964 1, 964		0	0	44. 00 45. 00
46. 00	1	SPEECH PATHOLOGY	128, 693	0	0	0	0	46. 00
47. 00	4	ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	167, 627 99, 865	565 889		0	0	48. 00 49. 00
50. 00		DENTAL CARE - TITLE XIX ONLY	0	0		0	ő	50.00
51.00		SUPPORT SURFACES	0	0		0	0	51.00
52. 00		OTHER ANCILLARY SERVICES TIENT SERVICE COST CENTERS	<u> </u>	0	0	0	0	52. 00
60.00	06000	CLI NI C	0	0	0	0	0	60. 00
61.00		RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200	OTHER OUTPATIENT SERVICES	0	0	o	0	0	62. 00 63. 00
	OTHER	REIMBURSABLE COST CENTERS	-1					
70.00		HOME HEALTH AGENCY COST	0	0		0	1	
71. 00 72. 00	07100	AMBULANCE CORF		0		0	0 0	71. 00 72. 00
73.00	07300	СМНС	0	0	0	0	0	73. 00
74. 00		OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100	INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW - SNF		0		0		82.00
83. 00 84. 00		HOSPI CE OTHER SPECI AL PURPOSE COST		0		0	0	83. 00 84. 00
89. 00		SUBTOTALS (sum of lines 1-84)	7, 501, 100	80, 396	44, 795	318	2, 078, 294	
00.00		I MBURSABLE COST CENTERS		0		^	_	00.00
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER & BEAUTY SHOP	0	0	0	0	0	90. 00 91. 00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	O	ō	o	0	0	92. 00
93.00		NONPALD WORKERS	0	0	0	0	0	93.00
94. 00 95. 00	4	PATIENTS' LAUNDRY OTHER NONREIMBURSABLE COST	0	0		0	0 0	94. 00 95. 00
98. 00		Cross Foot Adjustments	0	0	Ö	0	ő	98. 00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00	7	TOTAL	7, 501, 100	80, 396	44, 795	318	2, 078, 294	100.00

REHAB In Lieu of Form CMS-2540-10
Provider No.: 315014 Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared:

				T	o 12/31/2021		
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/19/2022 12: NURSI NG	59 pm
	Sect Control Boson Person	OPERATION,	LINEN SERVICE	I THOUGHT I THO	5.2.7	ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS 5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	7.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVEABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	454, 853	ł				5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	3, 640 4, 644		199, 980			6. 00 7. 00
8. 00	00800 DI ETARY	81, 018	l t	36, 281	710, 698		8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	3, 514	l t	1, 574		1, 120, 221	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	l .	0	0	17, 969	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	1, 067	0	478	0	0	12.00
13. 00	01300 SOCIAL SERVICE	3, 389	1	1, 518	0	30, 693	13.00
15. 00	01500 OTHER GENERAL SERVICES	0	0	0	0	36, 275	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	221 120	71 (01	142.001	710 (00	1 025 204	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	321, 120	71, 691	143, 801	710, 698	1, 035, 284 0	30. 00 31. 00
32. 00	03200 CF/11D			0	0		32. 00
33. 00	03300 OTHER LONG TERM CARE			_	0		33. 00
00.00	ANCI LLARY SERVICE COST CENTERS		<u> </u>				00.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	13, 304	1	5, 958		0	44.00
45. 00 46. 00	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	13, 304	0	5, 958	0	0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY				0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 828	ő	1, 714	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	6, 025	1	2, 698	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0		0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICES	0	0	0	0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1 0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC		1	0	0		61. 00
62. 00	06200 FQHC				0		62. 00
63. 00	06300 OTHER OUTPATIENT SERVICES	0	0	О	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0					70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71.00
72. 00 73. 00	07200 CORF 07300 CMHC	0			0	0	72. 00 73. 00
74. 00	07400 OTHER REIMBURSABLE COST			0	0		74.00
7 1. 00	SPECIAL PURPOSE COST CENTERS		,		0		71.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	1	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST	0 454, 853	1	0 199, 980	710 (00	1 120 221	84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	454, 853	71, 691	199, 980	710, 698	1, 120, 221	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER & BEAUTY SHOP	0	ł .	ō	0	Ö	91. 00
92.00	09200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS' LAUNDRY	0	_	0	0	0	94. 00
95. 00	09500 OTHER NONREI MBURSABLE COST	0	_	0	0	0	95. 00
98. 00 99. 00	Cross Foot Adjustments	0		0	0	0	98. 00 99. 00
100.00	Negative Cost Centers TOTAL	454, 853	71, 691	199, 980	710, 698		
100.00) IOTAL	1 434, 653	1 /1,091	1 77, 700	710,090	1, 120, 221	1.00.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315014

						To 12/31/2021	Date/Time Pre 5/19/2022 12:	
						OTHER GENERAL	37 177 2022 12.	J / piii
		Coat Contar Decement on	CENTRAL	MEDICAL	COCLAL CEDVI	SERVI CE	Cubtotal	
		Cost Center Description	CENTRAL SERVICES &	MEDI CAL RECORDS &	SOCIAL SERVI	CE S	Subtotal	
			SUPPLY	LI BRARY				
	CENED	AL CEDIUCE COST CENTERS	10.00	12. 00	13. 00	15. 00	16.00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT						2. 00
3.00	1	EMPLOYEE BENEFITS						3.00
4. 00 5. 00	1	ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6.00	00600	LAUNDRY & LINEN SERVICE						6. 00
7.00		HOUSEKEEPI NG						7. 00
8. 00 9. 00	1	DI ETARY NURSI NG ADMINI STRATI ON						8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY	67, 181					10.00
12.00		MEDICAL RECORDS & LIBRARY	0	26, 171		0.5		12.00
13. 00 15. 00	1	SOCIAL SERVICE OTHER GENERAL SERVICES	1, 871 2, 211	0		85 0 124, 784		13. 00 15. 00
13.00		I ENT ROUTI NE SERVI CE COST CENTERS	2,211		ή	0 124, 704		13.00
30.00		SKILLED NURSING FACILITY	63, 099	26, 171			6, 721, 856	1
31. 00 32. 00	1	NURSING FACILITY ICF/IID	0	0	1	0 0	0	
33. 00	1	OTHER LONG TERM CARE	o	0	1	0 0	0	1
	ANCI L	LARY SERVICE COST CENTERS					-	
40.00		RADI OLOGY LABORATORY	0	0	1	0 0	0	
41. 00 42. 00	1	LABORATORY INTRAVENOUS THERAPY	0	0		0 0		
43. 00	1	OXYGEN (INHALATION) THERAPY	o	0		0 0	0	1
44.00	1	PHYSI CAL THERAPY	0	0	4, 2			1
45. 00 46. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	4, 2	45 4, 643 0 0	174, 709 128, 693	1
47. 00	1	ELECTROCARDI OLOGY	Ö	0		0 0	0	1
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 2			1
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0	0	1, 9	22 2, 102 0 0	113, 996 0	1
51. 00	1	SUPPORT SURFACES	0	0		0 0	Ö	1
52. 00		OTHER ANCILLARY SERVICES	0	0		0 0	0	52. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	C	N	0 0	0	60. 00
61. 00		RURAL HEALTH CLINIC	o	0	1	0 0	0	
62. 00	06200	FQHC						62. 00
63. 00		OTHER OUTPATIENT SERVICES REIMBURSABLE COST CENTERS	0	0	0	0 0	0	63. 00
70. 00		HOME HEALTH AGENCY COST	O	0		0 0	0	70. 00
71. 00	07100	AMBULANCE	0	0		0 0	0	
72.00	07200	ł company of the comp	0	0		0 0	0	
73. 00 74. 00	07300	OTHER REIMBURSABLE COST	0	0		0 0	0	
	SPECI.	AL PURPOSE COST CENTERS		-	1			
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF			1			81. 00 82. 00
83. 00	1	HOSPI CE	o	0		0 0	0	1
84. 00	08400	OTHER SPECIAL PURPOSE COST	0	0	1	0 0	0	
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	67, 181	26, 171	114, 0	85 124, 784	7, 501, 100	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C)	0 0	0	90. 00
91. 00	09100	BARBER & BEAUTY SHOP	O	0		0 0	0	
92. 00 93. 00		PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	0			0	
94. 00	1	PATIENTS' LAUNDRY		0	Ó	o o	0	1
95.00		OTHER NONREIMBURSABLE COST	0	O		0 0	0	
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers	0	0		0	0	
100.00		TOTAL	67, 181	26, 171	114, 0	85 124, 784		
			'					

Provi der No.: 315014

| Peri od: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time | Prepared: | 5/19/2022 | 12: 59 pm |

				5/19/2	2022 12:59 pm
	Cost Center Description	Post Stepdown	Total		
		Adjustments			
		17. 00	18. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1. 00
2.00	00200 CAP REL COSTS - MOVEABLE EQUIPMENT				2. 00
3. 00	00300 EMPLOYEE BENEFITS				3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE				6. 00
7.00	00700 HOUSEKEEPI NG				7. 00
8.00	00800 DI ETARY				8. 00
9.00	00900 NURSING ADMINISTRATION				9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY				10.00
12.00	01200 MEDICAL RECORDS & LIBRARY				12. 00
13. 00	01300 SOCIAL SERVICE				13. 00
15. 00	01500 OTHER GENERAL SERVICES				15. 00
13.00					15.00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		(704 054		
30. 00	03000 SKILLED NURSING FACILITY	0	6, 721, 856		30.00
31. 00	03100 NURSING FACILITY	0	0		31.00
32. 00	03200 I CF/I I D	0	0		32. 00
33.00	03300 OTHER LONG TERM CARE	0	0		33.00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	0	0		40. 00
41.00	04100 LABORATORY	o	o		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	o		42. 00
43. 00	1	0	0		I
	04300 OXYGEN (INHALATION) THERAPY		405 040		43.00
44. 00	04400 PHYSI CAL THERAPY	0	185, 240		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	174, 709		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	128, 693		46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0		47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	176, 606		48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	l ol	113, 996		49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51. 00	05100 SUPPORT SURFACES	0	ő		51.00
52. 00		0	o		52.00
52.00	05200 OTHER ANCILLARY SERVICES	<u> </u>	U		52.00
	OUTPATIENT SERVICE COST CENTERS				
60. 00	06000 CLI NI C	0	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		61. 00
62.00	06200 FQHC				62. 00
63.00	06300 OTHER OUTPATIENT SERVICES	ol	o		63. 00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>		
70. 00	07000 HOME HEALTH AGENCY COST	0	0		70. 00
71. 00	07100 AMBULANCE		0		71.00
		1	-1		l l
72. 00	07200 CORF	0	0		72.00
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				80.00
81.00	08100 I NTEREST EXPENSE				81.00
82.00	1				82.00
83. 00	08300 HOSPI CE	o	О		83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST		o		84. 00
		1			•
89. 00	SUBTOTALS (sum of lines 1-84)	0	7, 501, 100		89. 00
	NONREI MBURSABLE COST CENTERS				
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100 BARBER & BEAUTY SHOP	0	0		91. 00
92.00	09200 PHYSICIANS' PRIVATE OFFICES	o	0		92.00
93. 00	09300 NONPALD WORKERS	o	o		93. 00
94. 00	09400 PATIENTS' LAUNDRY	ا	٥		94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST		0		95. 00
98. 00			0		98. 00
	Cross Foot Adjustments	-	O O		
99. 00	Negative Cost Centers	0	0		99. 00
100.00	D TOTAL	0	7, 501, 100		100. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315014

					То	12/31/2021	Date/Time Pre 5/19/2022 12:	pared:
				CAPI TAL REL	ATED COSTS		3/ 19/ 2022 12.	J4 pili
		Cook Cooker Decorated	Di marati	DI DCC 0	MOVEARIE	C	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVEABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
			Capi tal					
			Related Costs 0	1. 00	2.00	2A	3. 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	2/1	3.00	
1.00		CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00 3. 00	1	CAP REL COSTS - MOVEABLE EQUIPMENT EMPLOYEE BENEFITS	0	204	114	318	318	2. 00 3. 00
4. 00		ADMINISTRATIVE & GENERAL	O	13, 060		20, 337	0	4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	0	0	0	0	0	5. 00
6. 00 7. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	537 685	299 382	836 1, 067	0	6. 00 7. 00
8. 00		DI ETARY	0	11, 958		18, 620	0	8. 00
9. 00	4	NURSING ADMINISTRATION	O	519	289	808	0	9. 00
10. 00 12. 00		CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	0	0 157	0 88	0 245	0	10. 00 12. 00
13. 00		SOCIAL SERVICE	0	500		779	0	13. 00
15. 00	01500	OTHER GENERAL SERVICES	0	0	0	0	0	15. 00
30. 00	INPAT	IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY		47, 394	26, 407	73, 801	318	30. 00
31. 00	03100	NURSING FACILITY		47, 394	· ·	73, 801	0	31. 00
32. 00	03200	CF/IID	O	0	O	O	0	32. 00
33. 00		OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	O	0	0	0	0	40. 00
41.00	04100	LABORATORY	0	0	0	O	0	41. 00
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	0	0	0	0	0	42. 00 43. 00
44. 00		PHYSICAL THERAPY		1, 964	1, 094	3, 058	0	44. 00
45.00	04500	OCCUPATI ONAL THERAPY	0	1, 964	· ·	3, 058	0	45. 00
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	0	0	0	46. 00 47. 00
47.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS		565	315	880	0	47.00
49. 00	04900	DRUGS CHARGED TO PATIENTS	o	889		1, 384	0	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 52. 00		SUPPORT SURFACES OTHER ANCILLARY SERVICES	0	0		ol Ol	0	51. 00 52. 00
	OUTPA	TIENT SERVICE COST CENTERS			-	_		
60.00		CLINIC RURAL HEALTH CLINIC	0	0	0	0	0	60.00
61. 00 62. 00	06200		0	U	٩	U U	U	61. 00 62. 00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0	0	0	63. 00
70.00		REIMBURSABLE COST CENTERS		0		ما	0	70.00
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	0	0	0	0	0	70. 00 71. 00
72. 00	07200	CORF	0	0	0	O	0	72. 00
73.00	07300		0	0	0	0	0	73.00
74. 00		OTHER REIMBURSABLE COST AL PURPOSE COST CENTERS	l ol	U	UU	U	0	74. 00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00	1	INTEREST EXPENSE						81.00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0	0	0	0	82. 00 83. 00
84. 00		OTHER SPECIAL PURPOSE COST	o	0	Ö	ō	0	
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	0	80, 396	44, 795	125, 191	318	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	O	0	ol	0	90. 00
91. 00	09100	BARBER & BEAUTY SHOP	O	Ö	o	ō	0	91. 00
92.00	1	PHYSICIANS' PRIVATE OFFICES	0	0	0	o	0	92.00
93. 00 94. 00		NONPALD WORKERS PATLENTS' LAUNDRY		0		0	0	93. 00 94. 00
95.00		OTHER NONREI MBURSABLE COST	0	o	O	ō	0	95. 00
98.00		Cross Foot Adjustments				o		98.00
99. 00 100. 00		Negative Cost Centers TOTAL	0	80, 396	44, 795	0 125, 191	0 318	99. 00 100. 00
. 55. 50	-1	1 · - · · · -	١	55, 570	11,779	.20, 171	310	1.00.00

	n Financial Systems ATION OF CAPITAL RELATED COSTS	EAGLEVIEW HEAL		No.: 315014	Peri od:	u of Form CMS-: Worksheet B	2340-10
ALLOCA	ATTON OF CALLTAC RELATED 60313		Trovider	100 313014	From 01/01/2021	Part II	
					To 12/31/2021	Date/Time Pre 5/19/2022 12:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J4 pili
		& GENERAL	OPERATI ON,	LINEN SERVIC			
			MAINT. &				
			REPAI RS		7.00		
	CENEDAL CEDALCE COCT CENTEDO	4.00	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1			1.00
2.00	00200 CAP REL COSTS - MOVEABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	20, 337					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	(o			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	(0 83	6		6. 00
7.00	00700 HOUSEKEEPI NG	0	(0	0 1, 067		7. 00
8.00	00800 DI ETARY	0	(0	0 194	18, 814	8. 00
9.00	00900 NURSING ADMINISTRATION	0	`	0	0 8	0	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0		0	0	0	
12.00	01200 MEDI CAL RECORDS & LI BRARY	0		0	0 3	0	
13.00	01300 SOCIAL SERVICE	0		0	0 8	0	
15. 00	01500 OTHER GENERAL SERVICES INPATIENT ROUTINE SERVICE COST CENTERS	0		0	0 0	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	20, 337		0 83	6 767	18, 814	30.00
31. 00	03100 NURSING FACILITY	20, 337			0 0	0,014	31.00
32. 00	03200 CF/11D	0			0 0	0	
33. 00		0			0 0	0	
	ANCILLARY SERVICE COST CENTERS	<u>, </u>		- 1			
40.00	04000 RADI OLOGY	0	(0	0 0	0	40. 00
41. 00	04100 LABORATORY	0	(0	0 0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	(0	0 0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0		0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0		0	0 32	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0		0	0 32	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0		0	0	0	
47. 00	04700 ELECTROCARDI OLOGY	0		0	0 0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0		0	0 9 0 14	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		0	0 0	0	•
51.00	05100 SUPPORT SURFACES	0			0 0	0	1
52. 00	05200 OTHER ANCILLARY SERVICES	o o		Ö	0 0	0	
	OUTPATIENT SERVICE COST CENTERS	-		-1			
60.00	06000 CLI NI C	0	(0	0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	(0	0 0	0	61.00
62.00	06200 FQHC						62.00
63. 00	06300 OTHER OUTPATIENT SERVICES	0	(0	0 0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0			0	0	
71. 00	07100 AMBULANCE	0			0	0	71.00
72. 00	07200 CORF	0			0	0	72.00
73. 00 74. 00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0		0	0 0	0	
74.00	SPECIAL PURPOSE COST CENTERS	ı O		<u> </u>	0	0	74.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00		1					81.00
	08200 UTI LI ZATI ON REVI EW - SNF	1					82. 00
	08300 H0SPI CF	0	(o	0	0	83 00

20, 337

20, 337

0

83.00

84.00

89. 00

90.00

91.00

92.00 0

93.00

94.00

95.00 ol

18, 814

0

0

0 98. 00 99.00

0

18, 814 100. 00

0

0 0 0

0 0 0

836

1, 067

1, 067

836

83. 00 08300 HOSPI CE

08400 OTHER SPECIAL PURPOSE COST

NONREI MBURSABLE COST CENTERS

09300 NONPALD WORKERS

TOTAL

09400 PATIENTS' LAUNDRY

95. 00 09500 OTHER NONREIMBURSABLE COST

Cross Foot Adjustments

Negative Cost Centers

SUBTOTALS (sum of lines 1-84)

09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER & BEAUTY SHOP 09200 PHYSICIANS' PRIVATE OFFICES

84.00

89.00

90.00

91.00

92.00

93.00

94.00

98.00

99.00

100.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315014

					To 12/31/2021	Date/Time Pre 5/19/2022 12:	
						OTHER GENERAL	J 7 DIII
						SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	SOCIAL SERVICE		
		ADMI NI STRATI ON	SERVICES &	RECORDS &			
			SUPPLY	LI BRARY			
	CENEDAL CEDALCE COCT CENTERS	9. 00	10. 00	12. 00	13. 00	15. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100			I			1.00
2. 00	00200 CAP REL COSTS - MOVEABLE EQUIPMENT						2.00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY	01/					8.00
9. 00 10. 00	O0900 NURSI NG ADMI NI STRATI ON O1000 CENTRAL SERVI CES & SUPPLY	816	12				9. 00 10. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	13	13 0	1	8		12.00
13. 00	01300 SOCIAL SERVICE	22	0	l .	0 809		13. 00
15. 00	01500 OTHER GENERAL SERVICES	26	0	l .	0 0		1
	INPATIENT ROUTINE SERVICE COST CENTERS	'		•	<u>'</u>	•	
30.00	03000 SKILLED NURSING FACILITY	755	13	24	8 726	24	30. 00
31. 00	03100 NURSING FACILITY	0	0	1	0 0		31. 00
32. 00	03200 CF/IID	0	0	1	0 0		32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		O C	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY			ı			40.00
40. 00 41. 00	04100 LABORATORY	0	0	1	O C		40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY		0	1		-	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	o	0	1	o c	-	43. 00
44. 00	04400 PHYSI CAL THERAPY	o	0		0 30	1	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 30	1	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		0 0	_	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 9	0	48. 00
49. 00	O4900 DRUGS CHARGED TO PATIENTS O5000 DENTAL CARE - TITLE XIX ONLY	0	0	1	0 14 0 0	l .	49.00
50. 00 51. 00	05100 SUPPORT SURFACES		0	•	O C	-	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICES	0	0	1	o c		52.00
02.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	<u> </u>		02.00
60.00	06000 CLI NI C	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61. 00
62. 00	06200 FQHC						62. 00
63. 00	06300 OTHER OUTPATIENT SERVICES	0	0		O C	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		0	ı	ol c	0	70.00
70. 00 71. 00	07100 AMBULANCE		0		0 0		70. 00 71. 00
71.00	07200 CORF		0			0	71.00
73. 00	07300 CMHC	o	0		o c	Ö	73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0		o c	0	1
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF		0				82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST	0	0	1	O C	-	
89. 00	SUBTOTALS (sum of lines 1-84)	816	13	l .		l .	
07.00	NONREI MBURSABLE COST CENTERS	010	13	24	00 7	20	0 7. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91. 00	09100 BARBER & BEAUTY SHOP		0	l .	o c	l .	91. 00
92.00	09200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	1
93.00	09300 NONPAI D WORKERS	0	0	1	0 0	_	93. 00
94.00	09400 PATIENTS' LAUNDRY	0	0	1	0 0	_	94. 00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST	0	0		0 0	_	95. 00 98. 00
98.00	Cross Foot Adjustments Negative Cost Centers		0		o c	0	1
100.00	1 1 9	816	13	l .			100.00
. 55. 50	1	370	13	. 27	-1	. 20	,

Provi der No.: 315014

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/19/2022 12: 59 pm

					5/19/2022 12:	:59 pm
	Cost Center Description	Subtotal	Post Step-Down	Total		
		16. 00	Adjustments 17.00	18. 00		
	GENERAL SERVICE COST CENTERS	10.00	17.00	10.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200 CAP REL COSTS - MOVEABLE EQUIPMENT					2. 00
3.00	00300 EMPLOYEE BENEFITS					3. 00
4.00	00400 ADMINISTRATIVE & GENERAL					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE					6. 00
7.00	00700 HOUSEKEEPI NG					7. 00
8.00	00800 DI ETARY					8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY					10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY					12. 00
	01300 SOCIAL SERVICE					13. 00
	01500 OTHER GENERAL SERVICES					15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					1
30.00	03000 SKILLED NURSING FACILITY	116, 639	0	116, 639		30.00
31.00	03100 NURSING FACILITY		0	0		31. 00
32. 00	03200 CF/IID		0	0		32. 00
33. 00	03300 OTHER LONG TERM CARE		0	0		33. 00
	ANCILLARY SERVICE COST CENTERS					
40.00	04000 RADI OLOGY	C	0	0		40. 00
41.00	04100 LABORATORY	C	0	0		41.00
42.00	04200 I NTRAVENOUS THERAPY	C	0	0		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	0	0		43.00
44.00	04400 PHYSI CAL THERAPY	3, 121	0	3, 121		44.00
45.00	04500 OCCUPATI ONAL THERAPY	3, 121	0	3, 121		45. 00
46.00	04600 SPEECH PATHOLOGY	C	0	0		46. 00
47.00	04700 ELECTROCARDI OLOGY	C	0	0		47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	898	0	898		48. 00
	04900 DRUGS CHARGED TO PATIENTS	1, 412	. 0	1, 412		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0	0		50.00
51.00	05100 SUPPORT SURFACES	C	0	0		51.00
52.00	05200 OTHER ANCILLARY SERVICES	C	0	0		52. 00
	OUTPATIENT SERVICE COST CENTERS					
60.00	06000 CLI NI C	C	0	0		60. 00
61. 00	06100 RURAL HEALTH CLINIC	C	0	0		61. 00
	06200 FQHC					62. 00
63.00	06300 OTHER OUTPATIENT SERVICES	C	0	0		63.00
	OTHER REIMBURSABLE COST CENTERS					
	07000 HOME HEALTH AGENCY COST	C	0	0		70. 00
	07100 AMBULANCE	C	0	0		71. 00
72. 00	07200 CORF	C	0	0		72. 00
73. 00	07300 CMHC	C	0	0		73. 00
74. 00	07400 OTHER REIMBURSABLE COST	C	0	0		74. 00
	SPECIAL PURPOSE COST CENTERS	T	1	ı		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES					80. 00
81. 00	08100 I NTEREST EXPENSE					81. 00
	08200 UTILIZATION REVIEW - SNF					82. 00
	08300 HOSPI CE	C	0	0		83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST	C	0			84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	125, 191	0	125, 191		89. 00
	NONREI MBURSABLE COST CENTERS	_	_	T _		4
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	1	-		90.00
	09100 BARBER & BEAUTY SHOP	C		0		91.00
	09200 PHYSI CI ANS' PRI VATE OFFI CES	C	0	0		92. 00
	09300 NONPAI D WORKERS	_ C] 0	0		93. 00
94. 00	09400 PATIENTS' LAUNDRY		1 0	0		94. 00
95. 00	09500 OTHER NONREI MBURSABLE COST		1 0	0		95. 00
98. 00	Cross Foot Adjustments			0		98. 00
99.00	Negative Cost Centers	125 101	0	_		99.00
100.00	TOTAL	125, 191	0	125, 191		100. 00

REHAB In Lieu of Form CMS-2540-10
Provider No.: 315014 | Period: | Worksheet B-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				Τ̈́	o 12/31/2021	Date/Time Pre 5/19/2022 12:	
		CAPITAL REL	ATED COSTS			37 147 2022 12.	J4 pili
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVEABLE EQUI PMENT (SQUARE FEET)	BENEFITS	ADMINISTRATIVE & GENERAL (TOTAL PATIENT DAYS)	OPERATI ON,	
	OFFICE ASSESSMENT OF THE PROPERTY OF THE PROPE	1.00	2.00	3.00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES	8, 680					1.00
2. 00 3. 00 4. 00 5. 00 6. 00	00200 CAP REL COSTS - MOVEABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	22 1, 410 0 58	8, 680 22 1, 410 0 58	23, 434 0 0 0	23, 434 0 0	7, 248 58	6. 00
7. 00 8. 00 9. 00 10. 00 12. 00	00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSI NG ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01200 MEDICAL RECORDS & LI BRARY	74 1, 291 56 0 17	74 1, 291 56 0 17	0 0 0 0	0 0	74 1, 291 56 0 17	8. 00 9. 00 10. 00 12. 00
13. 00 15. 00	01300 SOCI AL SERVI CE 01500 OTHER GENERAL SERVI CES	54 0	54 0			54 0	1
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	5, 117	5, 117	23, 434	23, 434	5, 117	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0	0 0	0	0	0	31. 00 32. 00
40. 00	04000 RADI OLOGY	0	0				1
41. 00 42. 00 43. 00 44. 00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 0 0 212	0 0 0 212	0	0	0 0 212	42. 00 43. 00 44. 00
45. 00 46. 00 47. 00 48. 00	O4500 OCCUPATI ONAL THERAPY O4600 SPEECH PATHOLOGY O4700 ELECTROCARDI OLOGY O4800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	212 0 0 61	212 0 0 61	0 0 0	0	212 0 0 61	46. 00 47. 00 48. 00
49. 00 50. 00 51. 00 52. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICES OUTPATIENT SERVICE COST CENTERS	96 0 0 0	96 0 0	0	0		50. 00 51. 00
60. 00 61. 00 62. 00 63. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC 06300 OTHER OUTPATIENT SERVICES	0 0	0	0	0	0	61. 00 62. 00
71. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07200 CORF	0 0 0	0 0	0	0	0	71. 00
73. 00 74. 00	07300 CMHC 07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0				1
80. 00 81. 00 82. 00 83. 00 84. 00 89. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST	0 0	0	0	0	0	84. 00
	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	8, 680	8, 680				
91. 00 92. 00 93. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER & BEAUTY SHOP 09200 PHYSICIANS' PRIVATE OFFICES 09300 NONPAID WORKERS	0 0 0 0	0 0 0 0	1	0	0 0 0	91. 00 92. 00 93. 00
94. 00 95. 00 98. 00 99. 00	09400 PATIENTS' LAUNDRY 09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments Negative Cost Centers	0 0	0	0	0	0	95. 00 98. 00 99. 00
102.00	Part I)	80, 396	44, 795 5 160714				
103. 00 104. 00	Cost to be allocated (per Wkst. B, Part II)	9. 262212	5. 160714	318	20, 337		104. 00
105. 00	Unit cost multiplier (Wkst. B, Part			0. 013570	0. 867842	0. 000000	105. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315014 | Peri od: | Worksheet B-1 | From 01/01/2021 | To 11/21/2021 | Date/Time Prop.

			To	o 12/31/2021	Date/Time Pre	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	5/19/2022 12: CENTRAL	59 pm
	LINEN SERVICE	(SQUARE	(TOTAL PATIENT	ADMI NI STRATI ON	SERVICES &	
	(TOTAL PATIENT DAYS)	FEET)	DAYS)	(GROSS	SUPPLY (GROSS	
	r			SALARI ES)	SALARI ES)	
GENERAL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2.00 00200 CAP REL COSTS - MOVEABLE EQUIPMENT						2. 00
3. 00 00300 EMPLOYEE BENEFITS						3. 00
4.00 OO400 ADMINISTRATIVE & GENERAL 5.00 OO500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE	23, 434					6. 00
7. 00 00700 HOUSEKEEPI NG	0	7, 116				7. 00
8. 00	0	1, 291		2 145 762		8. 00 9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY		56 0		2, 145, 763 34, 420	2, 111, 343	10. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	17	0	0	0	12.00
13. 00 01300 SOCIAL SERVICE	0	54	1	58, 792	58, 792	13.00
15. 00 O1500 OTHER GENERAL SERVICES I NPATI ENT ROUTI NE SERVICE COST CENTERS	0	0) 0	69, 484	69, 484	15. 00
30. 00 03000 SKILLED NURSING FACILITY	23, 434	5, 117	23, 434	1, 983, 067	1, 983, 067	30. 00
31.00 03100 NURSING FACILITY	0	0	_	0	0	31. 00
32.00 03200 1 CF/IID 33.00 03300 0THER LONG TERM CARE	0 0	0	_	0	0	32. 00 33. 00
33. 00 O3300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	<u> </u>		0	U	0	33.00
40. 00 04000 RADI OLOGY	0	O	0	0	0	40.00
41. 00 04100 LABORATORY	0	0	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY 43.00 04300 0XYGEN (INHALATION) THERAPY	0	0		O O	0	42. 00 43. 00
44. 00 04400 PHYSI CAL THERAPY	0	212		o	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	212	0	0	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	0	1	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 61	1	0	0	47. 00 48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	O	96	•	o	0	49. 00
50.00 O5000 DENTAL CARE - TITLE XIX ONLY	0	0	0	o	0	50.00
51. 00 05100 SUPPORT SURFACES 52. 00 05200 OTHER ANCI LLARY SERVICES	0	0	0	0	0	51. 00 52. 00
OUTPATIENT SERVICE COST CENTERS	0		<u>, </u>	<u> </u>	0	32.00
60. 00 06000 CLI NI C	0	O		0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC 62. 00 06200 FOHC	0	C	0	0	0	61. 00 62. 00
63. 00 06300 OTHER OUTPATIENT SERVICES	0	O	o	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS						
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE 72. 00 07200 CORF	0	0		0	0	71. 00 72. 00
73. 00 07300 CMHC	O	0	o o	Ö	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 NTEREST EXPENSE						81. 00
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83. 00 08300 HOSPI CE 84. 00 08400 OTHER SPECI AL PURPOSE COST	0	0	0	0	0	83. 00
84.00 O8400 OTHER SPECIAL PURPOSE COST 89.00 SUBTOTALS (sum of lines 1-84)	23, 434	7, 116	23, 434	2, 145, 763	0 2, 111, 343	84. 00 89. 00
NONREI MBURSABLE COST CENTERS		.,		=7 : :=7 :==9	=, ,	
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
91. 00 09100 BARBER & BEAUTY SHOP 92. 00 09200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	91. 00 92. 00
93. 00 09300 NONPALD WORKERS	O	0	o o	o	0	93. 00
94. 00 09400 PATI ENTS' LAUNDRY	0	0	0	0	0	94. 00
95. 00 O9500 OTHER NONREIMBURSABLE COST 98. 00 Cross Foot Adjustments	0	O	0	0	0	95. 00 98. 00
99.00 Negative Cost Centers						99. 00
102.00 Cost to be allocated (per Wkst. B,	71, 691	199, 980	710, 698	1, 120, 221	67, 181	
Part I) 103.00 Unit cost multiplier (Wkst. B, Part I)	2 050272	20 1020/7	20 2274.44	0 533043	0 021010	102 00
103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B,	3. 059273 836	28. 102867 1, 067		0. 522062 816	0. 031819 13	103.00
Part II)						
105.00 Unit cost multiplier (Wkst. B, Part	0. 035675	0. 149944	0. 802851	0. 000380	0. 000006	105. 00
11)	ı I		1	l		

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315014 Peri od:

Period: Worksheet B-1 From 01/01/2021

Date/Time Prepared:

12/31/2021

5/19/2022 12:59 pm OTHER GENERAL SERVI CE Cost Center Description MEDI CAL SOCIAL SERVICE (SQUARE RECORDS & LI BRARY (SQUARE FEET) (TOTAL PATIENT FEET) DAYS) 13.00 15. 00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVEABLE EQUIPMENT 1 00 1 00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4 00 4 00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 7.00 00700 HOUSEKEEPI NG 7.00 00800 DI ETARY 8 00 8 00 9.00 00900 NURSING ADMINISTRATION 9.00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 23.434 01300 SOCIAL SERVICE 13.00 13.00 5, 698 01500 OTHER GENERAL SERVICES 5, 698 15.00 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 5, 117 30.00 23, 434 5.117 31.00 03100 NURSING FACILITY C 31 00 32.00 03200 | CF/IID 0 0 32.00 33.00 03300 OTHER LONG TERM CARE 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 O 40.00 04100 LABORATORY 0 41.00 41.00 00000000000 0 42.00 04200 I NTRAVENOUS THERAPY 0 42.00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 C 44.00 04400 PHYSI CAL THERAPY 212 212 44.00 04500 OCCUPATIONAL THERAPY 45.00 212 212 45.00 46.00 04600 SPEECH PATHOLOGY 0 46.00 C 47.00 04700 ELECTROCARDI OLOGY C 0 47 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 61 61 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 96 96 49.00 05000 DENTAL CARE - TITLE XIX ONLY 50.00 50.00 C 0 51.00 05100 SUPPORT SURFACES 0 0 51.00 05200 OTHER ANCILLARY SERVICES 0 52.00 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 60.00 06000 CLI NI C 0 Ω 0 61.00 06100 RURAL HEALTH CLINIC 0 C 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICES 63 00 0 Ω 0 63 00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 Ω 0 70.00 07100 AMBULANCE 0 71.00 0 0 71.00 07200 CORF 0 0 72 00 72 00 Ω 73.00 07300 CMHC 0 C 0 73.00 07400 OTHER REIMBURSABLE COST 0 74.00 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 00 80 00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 08300 HOSPI CE 83.00 83.00 0 08400 OTHER SPECIAL PURPOSE COST 84.00 0 84 00 89.00 SUBTOTALS (sum of lines 1-84) 23, 434 5,698 5, 698 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 91.00 09100 BARBER & BEAUTY SHOP 0 0 91.00 09200 PHYSICIANS' PRIVATE OFFICES 0 0 92.00 0 92.00 0 09300 NONPALD WORKERS 93.00 0 0 93.00 09400 PATIENTS' LAUNDRY 0 94.00 C 94.00 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 95.00 98.00 Cross Foot Adjustments 98.00 Negative Cost Centers 99.00 99.00 102.00 Cost to be allocated (per Wkst. B, 26, 171 114, 085 124, 784 102.00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 1. 116796 20.021938 21.899614 103.00 104.00 Cost to be allocated (per Wkst. B, 248 104.00 809 26 Part II) 0. 141980 0.004563 105.00 0.010583 105.00 Unit cost multiplier (Wkst. B, Part 11)

Health Financial Systems	EAGLEVIEW HEALTH &	REHAB	In Lie	u of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY	AND OUTPATIENT COST CENTERS	Provi der No.: 315014	Peri od:	Worksheet C

To 12/31/2021 Date/Time Prepared: 5/19/2022 12:59 pm Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, col. 18) 1.00 di vi ded by col . 2 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0.000000 40.00 41.00 04100 LABORATORY 0 0 0.000000 41.00 42.00 0 04200 I NTRAVENOUS THERAPY 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 185, 240 305, 915 0.605528 44.00 04500 OCCUPATIONAL THERAPY 321, 919 45.00 174, 709 0.542711 45.00 04600 SPEECH PATHOLOGY 128, 693 267, 840 0.480485 46.00 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 176, 606 5, 230 33.767878 48.00 04900 DRUGS CHARGED TO PATIENTS 1. 300241 49.00 49.00 113, 996 87, 673 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 50.00 51.00 05100 SUPPORT SURFACES 0 0.000000 51.00 52.00 05200 OTHER ANCILLARY SERVICES 0 10, 757 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0 0.000000 60.00 06000 CLI NI C 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FQHC 62.00 63. 00 06300 OTHER OUTPATIENT SERVICES 63.00 0 0.000000 0 71. 00 | 07100 | AMBULANCE 0.000000 71.00 100.00 Total 779, 244 999, 334 100.00

Health Financial Systems	EAGLEVIEW HEA	NITH & RFHAR		In lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	ENGLEVI EW TILE			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I	pared:
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care Pi	rogram Charges		Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B		Part B (col. 1	
	to Charges (Fr. Wkst. C			x col. 2)	x col. 3)	
	Column 3)					
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					
ANCILLARY SERVICE COST CENTERS		_				
40. 00 04000 RADI OLOGY	0. 000000			0	0	
41. 00 04100 LABORATORY	0. 000000			0 0	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0 0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0	0	
44. 00 O4400 PHYSI CAL THERAPY	0. 605528			0 151, 334	l .	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 542711			0 128, 138		
46. 00 04600 SPEECH PATHOLOGY	0. 480485			0 72, 940		
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 000000 33. 767878			0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49.00 04900 DRUGS CHARGED TO PATIENTS				0 100 751	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	1. 300241 0. 000000	83, 639		0 108, 751	0	50.00
51. 00 05100 SUPPORT SURFACES	0. 000000			0	0	
52. 00 05200 OTHER ANCILLARY SERVICES	0.000000			0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	7, 271		0 0	0	32.00
60. 00 06000 CLINIC	0. 000000	0		0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.00000					61.00
62. 00 06200 FQHC						62. 00
63. 00 06300 OTHER OUTPATIENT SERVICES	0. 000000	0		o o	0	•
71. 00 07100 AMBULANCE (2)	0. 000000			ol	Ö	
100.00 Total (Sum of lines 40 - 71)		730, 768		0 461, 163	0	100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.			•		

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

Heal th	Financial Systems	EAGLEVIEW HEA	LTH & REHAB		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315014	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/19/2022 12:	pared: 59 pm
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	ost to charges	(From Workshee	t C, column 3	, line 49)	1. 300241	1.00
2.00	Program vaccine charges (From your reco					0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	vi ders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,	Costs to Tota		Health Costs for Pass	
		18	Part I, Col. 14)	Costs - Part	, , , ,	Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)	•	3 X 001. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	0	C	0.0000		0	
41. 00	04100 LABORATORY	0	(0. 00000		0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	C	0. 00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	(0.0000		0	
44.00	04400 PHYSI CAL THERAPY	185, 240		0.0000		0	
	04500 OCCUPATI ONAL THERAPY	174, 709		0.0000		0	
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	128, 693		0.0000		0 0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	176, 606		0.0000		0	
	04900 DRUGS CHARGED TO PATIENTS	113, 996		0.0000		0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	113, 770		0.0000		0	
	05100 SUPPORT SURFACES	0		0.0000		0	
	05200 OTHER ANCILLARY SERVICES	0		0.0000		Ö	
100.00		779, 244	Ċ	•	461, 163	-	100.00
		'	•	1	,		

	Financial Systems EAGLEVIEW HEALTH			u of Form CMS-2	
MPU	TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315014	Peri od: From 01/01/2021	Worksheet D-1 Parts I-II	
			To 12/31/2021	Date/Time Pre	pare
			12, 01, 2021	5/19/2022 12:	
		Title XVIII	Skilled Nursing	PPS	
			Facility Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days including private room days			23, 434	1 1
00	Private room days			1, 625	
00	Inpatient days including private room days applicable to the Pr	ogram		3, 023	3
00	Medically necessary private room days applicable to the Program			1, 625	4
0	Total general inpatient routine service cost			6, 721, 856	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
0	General inpatient routine service charges			6, 146, 902	
0	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		1. 093536	
0	Enter private room charges from your records			457, 590	
0	Average private room per diem charge (Private room charges line 2)	8 divided by private	room days, line	281. 59	9
00	'				10
00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)				11
00					
00	00 Average per diem private room cost differential (Line 7 times line 12)				13
00	00 Private room cost differential adjustment (Line 2 times line 13)				14
00		differential (Line 5	minus line 14)	6, 221, 470	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		1	2/5 10	١.,
00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		265. 49	
00	Program routine service cost (Line 3 times line 16)	i 4 ti 1i 12)		802, 576	
00	Medically necessary private room cost applicable to program (I Total program general inpatient routine service cost (Line 17			500, 386 1, 302, 962	
00	Capital related cost allocated to inpatient routine service cost		t II column 19	116, 639	
00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ts (110m mkst. b, 14	t ii cordiiii io,	110,037	20
00	Per diem capital related costs (Line 20 divided by line 1)			4. 98	21
00	Program capital related cost (Line 3 times line 21)			15, 055	22
00	Inpatient routine service cost (Line 19 minus line 22)			1, 287, 907	23
00	Aggregate charges to beneficiaries for excess costs (From prov	ider records)		0	24
00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	1, 287, 907	25
00	Enter the per diem limitation (1)				26
00	Inpatient routine service cost limitation (Line 3 times the per				27
00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)	lesser of line 25 or	line 27)		28
Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX		1
				1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		1. 00	
0	Total SNF inpatient days			23, 434	1 1
	Drogram input int days (see instructions)			,	

2. 00 3. 00 4. 00 5. 00

3, 023

Program inpatient days (see instructions)
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)
Nursing & allied health ratio. (line 2 divided by line 1)
Program nursing & allied health costs for pass-through. (line 3 times line 4)

2.00

4. 00 5. 00

ealth Financial Systems	EAGLEVIEW HEALTH	& REHAB	In Lie	u of Form CMS-2	2540-1
OMPUTATION OF INPATIENT ROUTINE COSTS		Provider No.: 315014	Peri od: From 01/01/2021	Worksheet D-1 Parts I-II	
			To 12/31/2021	Date/Time Pre	
		Title XIX	Skilled Nursing	5/19/2022 12:	59 pm
		TI LIE XIX	Facility		
				1. 00	
PART I CALCULATION OF INPATIENT ROUT	INE COSTS			1. 00	
I NPATI ENT DAYS]
.00 Inpatient days including private roo	m days			23, 434	1.0
OPPrivate room days				15 001	
On Inpatient days including private room Medically necessary private room day				15, 891 0	3. 0 4. 0
00 Total general inpatient routine serv	11 9	ı		6, 721, 856	
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				0,72.7000	1 0.0
00 General inpatient routine service ch				0	6.0
00 General inpatient routine service co	,	vided by line 6)		0. 000000	1
00 Enter pri vate room charges from your				0	8. 0 9. 0
.00 Average private room per diem charge					
00 Enter semi-private room charges from your records					10.0
00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by					11. 0
semi-private room days)					
	00 Average per diem private room charge differential (Line 9 minus line 11)				
3.00 Average per diem private room cost				0.00	
4.00 Private room cost differential adjust 5.00 General inpatient routine service co			minus lins 14)	0 (721 054	14. 0 15. 0
PROGRAM I NPATIENT ROUTINE SERVICE CO		differential (Line 5	III Tius TTTle 14)	6, 721, 856	15.0
6.00 Adjusted general inpatient service of	ost per diem (Line 15 divi	ded by line 1)		286. 84	16.0
7.00 Program routine service cost (Line	,			4, 558, 174	
B. 00 Medically necessary private room cos				0	
9.00 Total program general inpatient rou [.] 0.00 Capital related cost allocated to in			t II oolumn 10	4, 558, 174	
line 30 for SNF; line 31 for NF, or		SIS (FIOII WRST. B, Par	t II Corumn 18,	116, 639	20.0
1.00 Per diem capital related costs (Lin	· · · · · · · · · · · · · · · · · · ·			4. 98	21.0
2.00 Program capital related cost (Line	,			79, 137	22. 0
8.00 Inpatient routine service cost (Lin				4, 479, 037	
4.00 Aggregate charges to beneficiaries				0	24.0
5.00 Total program routine service costs	for comparison to the cost	limitation (Line 23 mi	nus line 24)	4, 479, 037	
 0.00 Enter the per diem limitation (1) 7.00 Inpatient routine service cost limit 	ation (line 2 times the per	diom limitation line	26) (1)	0.00	26. 0 27. 0
3.00 Reimbursable inpatient routine servi				4, 558, 174	
(Transfer to Worksheet E, Part II, I			27)	1, 555, 174	20.0
) Lines 26 and 27 are not applicable for	, ,	ed for title V and or t	itle XIX		
				1.00	

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	23, 434	1.00
2.00	Program inpatient days (see instructions)	15, 891	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. 678117	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	EAGLEVIEW HEALTH &	& REHAB	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provider No.: 315014	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 5/19/2022 12:59 pm
		Title XVIII	Skilled Nursing	PPS

-		Title XVIII	Skilled Nursing Facility	PPS	<u> </u>
			raciiity		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSI	EMENT			
1.00	Inpatient PPS amount (See Instructions)			1, 651, 873	1.00
2.00	Nursing and Allied Health Education Activities (pass through page 1975)	yments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			1, 651, 873	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			207, 575	5. 00
6.00	Allowable bad debts (From your records)			21, 268	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		105, 934	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			13, 824	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)			1, 458, 122	11. 00
12.00	Interim payments (See instructions)			1, 444, 298	12. 00
13.00	Tentati ve 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				13, 824	15. 00
16. 00	Protested amounts (Nonallowable cost report items in accordance			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	,			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	Pri mary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00				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)	a with CMC Dub 15 2	continu 11F 2	0	29. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with two Pub. 15-2,	Section 115.2	0	30. 00

From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/19/2022 12:59 pm

		Ti +1	e XVIII	Skilled Nursing	5/19/2022 12: PPS	59 biii
		11 (1	e viii	Facility	FF3	
		Inpatien	it Part A		t B	
			1			
	•	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1. 00	Total interim payments paid to provider	1. 00	2. 00 1, 444, 298	3. 00	4.00	1. 00
2. 00	Interim payments payable on individual bills, either		1, 444, 290)	0	
2.00	submitted or to be submitted to the contractor for		`			2.00
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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)					
	Program to Provider					1
3. 01	ADJUSTMENTS TO PROVIDER			O	0	3. 01
3.02			(o l	0	3. 02
3.03			•	D	0	
3.04				D	0	
3. 05			(0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		1 ,		0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM		•			
3. 52					0	
3. 53				o o	Ö	
3.54)	0	3. 54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50			D	0	3. 99
	- 3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 444, 298	3	0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			~I		
5. 01 5. 02	TENTATI VE TO PROVI DER				0	
5. 02						
5. 05	Provider to Program		<u>'</u>	21		3.03
5. 50	TENTATI VE TO PROGRAM			o l	0	5. 50
5. 51				o l	0	5. 51
5. 52				O	0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			O .	0	5. 99
6. 00	- 5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	PROGRAM TO PROVIDER		13, 82	4	0	6. 01
6. 02	PROVI DER TO PROGRAM			o l	0	
7. 00	Total Medicare program liability (see instructions)		1, 458, 122		0	7. 00
			Contrac	tor Name	Contractor	
				00	Number	
8 00	Name of Contractor		1.	. 00	2. 00	8. 00
	Invalle of Contractor				l	J 0.00

⁽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.

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

Provi der No.: 315014 | Peri od: From 01/01/202 To 12/31/202

| Period: | Worksheet G | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/19/2022 12:59 pm |

oni y)		Conoral Fund	Cassifia	Fadaumon+ Fund	5/19/2022 12:	59 pm
		General Fund	Specific E Purpose Fund	Endowment Fund	Plant Fund	
	Assets	1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					1
1. 00	Cash on hand and in banks	316, 557	0	0	0	
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	0	0	0	1
4. 00 5. 00	Accounts receivable Other receivables	418, 921	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts	-14	_	0	0	
0.00	recei vabl e	'-		ď	O] 0.0
7.00	Inventory	0	0	o	0	7.0
8.00	Prepai d expenses	61, 843	0	o	0	
9.00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10) FIXED ASSETS	797, 307	0	0	0	11. 0
12. 00	Land	200, 000	0	ol	0	12.0
13. 00	Land improvements	200,000	0	0	0	
14. 00	Less: Accumulated depreciation	l o	Ö	o	0	
15. 00	Bui I di ngs	1, 824, 000	0	0	0	15.0
16. 00	Less Accumulated depreciation	-1, 679, 595	0	0	0	16.0
17. 00	Leasehold improvements	1, 456, 756		0	0	1
18. 00	Less: Accumulated Amortization	-674, 481	0	0	0	
19. 00	Fixed equipment	175, 158		0	0	1
20.00	Less: Accumulated depreciation	-169, 286		0	0	
21. 00 22. 00	Automobiles and trucks	0	0	0	0	
23. 00	Less: Accumulated depreciation Major movable equipment	647, 550	1 1	0	0	1
24. 00	Less: Accumulated depreciation	-563, 685		0	0	
25. 00	Mi nor equi pment - Depreci abl e	000,000	Ö	o	0	
26. 00	Mi nor equipment nondepreciable	0	O	o	0	
27. 00	Other fixed assets	0	0	o	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1, 216, 417	0	0	0	28.0
	OTHER ASSETS					1
29. 00	Investments	0	0	0	0	1
30.00	Deposits on Leases	0	0	0	0	
31.00	Due from owners/officers	4 77/ 210	0	0	0	
32. 00 33. 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	4, 776, 218 4, 776, 218		0	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	6, 789, 942		0	0	
0 11 00	Liabilities and Fund Balances	0,707,712	<u> </u>	<u> </u>		1
	CURRENT LIABILITIES	_				
35. 00	Accounts payable	250, 862		0	0	
36. 00	Salaries, wages, and fees payable	321, 766	0	0	0	1
37. 00	Payroll taxes payable	0	0	0	0	
38. 00 39. 00	Notes & Loans payable (Short term)	0	0	0	0	
40. 00	Deferred income Accel erated payments		U	U	U	40.0
41. 00	Due to other funds		0	0	0	
42. 00	Other current liabilities	738, 792		o	0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 311, 420		o	0	
	LONG TERM LIABILITIES					
44. 00	Mortgage payable	4, 771, 266	0	0	0	44. C
45. 00	Notes payable	0	0	0	0	1
46. 00	Unsecured Loans	0	0	0	0	1
47. 00	Loans from owners:	0	0	0	0	
48. 00	Other long term liabilities	5(0,000	0	0	0	
49. 00 50. 00	COVID EXCHANGE TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	569, 233 5, 340, 499		O O	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	6, 651, 919		0	0	
71.00	CAPI TAL ACCOUNTS	0,001,717	J J	<u> </u>		1 0 \
52. 00	General fund balance	138, 023				52. (
53. 00	Specific purpose fund		0			53. (
54. 00	Donor created - endowment fund balance - restricted			0		54. (
55. 00	Donor created - endowment fund balance - unrestricted			О		55. (
56. 00	Governing body created - endowment fund balance			0	_	56. (
7.00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58. (
	mont agament and avnancian					1
58. 00	replacement, and expansion	120 022		_	^	50 0
	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	138, 023 6, 789, 942		0	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES EAGLEVIEW HEALTH & REHAB In Lieu of Form CMS-2540-10

Provider No.: 315014 Period: From 01/01/2021 Worksheet G-1

					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 12:	
		General F	und	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0 0 0 0	313, 465 -175, 442 138, 023		0 0 0 0 0 0 0 0	0 0 0 0	9. 00 10. 00 11. 00 12. 00
15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0	0 138, 023 PI ant		0 0 0		15. 00 16. 00 17. 00 18. 00 19. 00
	T=	6. 00	7. 00	8. 00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0	0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Heal th	Financial Systems EAGLEVIEW HEALTH 8	REHAB		In Lie	u of Form CMS-:	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/19/2022 12:	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		6, 146, 90	2	6, 146, 902	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)		6, 146, 90	2	6, 146, 902	5.00
	All Other Care Services			_		
6. 00	ANCI LLARY SERVI CES		999, 33	5 0	999, 335	
7. 00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9. 00	AMBULANCE			0	0	9. 00
10. 00	RURAL HEALTH CLINIC			0	0	1
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
11. 10	CORF			0	0	
12. 00	HOSPI CE			0	0	12. 00
	OTHER (SPECIFY)			0	0	
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 Worksheet G-3, Line 1)	to	7, 146, 23	7 0	7, 146, 237	14. 00

12.00	HUSPICE	U	υ	U	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	7, 146, 237	0	7, 146, 237	14.00
	Worksheet G-3, Line 1)				
	Cost Center Description				
			1. 00	2. 00	
	PART II - OPERATING EXPENSES				
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			7, 501, 100	1. 00
2.00	Add (Specify)		0		2. 00
3.00			0		3. 00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8. 00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			7, 501, 100	15.00

	y .				u of Form CMS-2	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSE	S	Provi der No.: 315014	Peri od: From 01/01/2021	Worksheet G-3	
				To 12/31/2021	Date/Time Pre	nared:
				10 12/31/2021	5/19/2022 12:	
	·					
					1. 00	
1.00	Total patient revenues (From Wkst. G-2, Par	t I, col. 3, line 1	4)		7, 146, 237	1. 00
2.00	Less: contractual allowances and discounts or	n patients accounts			378, 253	2. 00
3.00	Net patient revenues (Line 1 minus line 2)				6, 767, 984	3. 00
4.00	Less: total operating expenses (From Workshee	et G-2, Part II, li	ne 15)		7, 501, 100	4. 00
5.00	Net income from service to patients (Line 3 r	minus 4)			-733, 116	5. 00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6. 00
7.00	7.00 Income from investments					7. 00
8.00	8.00 Revenues from communications (Telephone and Internet service)					8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				0	10.00
11. 00	Rebates and refunds of expenses				0	11. 00
12.00	Parking Lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13. 00
14.00	Revenue from meals sold to employees and gues	sts			0	14. 00
15. 00	Revenue from rental of living quarters				0	15. 00
16. 00	Revenue from sale of medical and surgical sup	oplies to other tha	n patients		0	16. 00
17. 00	Revenue from sale of drugs to other than pati	ents			0	17. 00
18. 00	Revenue from sale of medical records and abs	tracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19. 00
20.00	Revenue from gifts, flower, coffee shops, car	nteen			0	20.00
21. 00	Rental of vending machines				0	21. 00
22. 00	Rental of skilled nursing space				0	22. 00
23. 00	Governmental appropriations				0	23. 00
24. 00	OTHER I NCOME				557, 674	24. 00
24 50	COVID 10 DHE Funding				· Λ	24 50

557, 674

0

0

0 30.00

-175, 442 31.00

24.50 25. 00

26.00 27. 00 28. 00 29. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (Sum of lines 6 - 24)
26.00 Total (Line 5 plus line 25)
27.00 Other expenses (specify)

30.00 Total other expenses (Sum of lines 27 - 29)
31.00 Net income (or loss) for the period (Line 26 minus line 30)

28. 00

29. 00