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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 5/19/2022 12:59 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/19/2022 Time: 12:59 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
3.01 [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no.

Contractor use only

4. [1] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

5. Date Received: _____

6. Contractor No. _____
7. [N] First Cost Report for this Provider CCN
8. [N] Last Cost Report for this Provider CCN
9. NPR Date: _____
10. [0] If line 4, column 1 is "4": Enter number of times reopened
11. Contractor Vendor Code 4
12. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by 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 FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Robert 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	CFO			3
4	Date	05/19/2022 12:59:20 PM			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII 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.

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

Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/19/2022 12:59 pm

	1.00	2.00	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	Zip Code: 08318	2.00
3.00	County: SALEM	CBSA Code: 48864	Urban/Rural: U	3.00
3.01		CBSA Code:		3.01

		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
					V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:							
4.00	SNF	EAGLEVIEW HEALTH & REHAB	315014	01/01/1967	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00

		From:	To:	
		1.00	2.00	
14.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	14.00
15.00	Type of Control (See Instructions)	5		15.00

		Y/N	
		1.00	
	Type of Freestanding Skilled Nursing Facility		
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.	Y	18.00
	Miscellaneous Cost Reporting Information		
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.01
	Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.		
20.00	Straight Line	125,191	20.00
21.00	Declining Balance	0	21.00
22.00	Sum of the Year's Digits	0	22.00
23.00	Sum of line 20 through 22	125,191	23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.	0	24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)	N	25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	N	26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)	N	27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)	N	28.00

		Part A	Part B	Other	
		1.00	2.00	3.00	
	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.				
29.00	Skilled Nursing Facility	N	N		29.00
30.00	Nursing Facility			N	30.00
31.00	ICF/IID				31.00
32.00	SNF-Based HHA	N	N		32.00
33.00	SNF-Based RHC		N		33.00
34.00	SNF-Based FQHC		N		34.00
35.00	SNF-Based CMHC		N		35.00
36.00	SNF-Based OLTC				36.00

		Y/N		
		1.00	2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)	N		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)	N		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.	1		39.00

		Premiums	Paid Losses	Self Insurance	
		1.00	2.00	3.00	
41.00	List malpractice premiums and paid losses:	148,750	0	0	41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX INDENTIFICATION DATA	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/19/2022 12:59 pm

		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	Y	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.	HB2128	44.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter the name and address of the home office on the lines below.			
45.00	Name: AMERICAN HEALTH CORPORATION	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 12501	45.00
46.00	Street: 200 BARR HARBOR RIVE	PO Box:		46.00
47.00	City: WESTCONSHOHOCKEN	State: PA	Zip Code: 19428	47.00

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

Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/19/2022 12:59 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)			
	Completed by All Skilled Nursing Facilites			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N		8.00

		Y/N	
		1.00	
	Bad Debts		
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.	Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.	N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.	N	11.00
	Bed Complement		
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.	N	12.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4.(see Instructions.)		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 4.		Y	04/25/2022	Y	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		N		N	18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/19/2022 12:59 pm

		1.00	2.00	
	Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ROBERT	CONNER	19.00
20.00	Enter the employer/company name of the cost report preparer.	AMERICAN HEALTH CORPORATION		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	610-890-8977	BOB@AMERICANHEALTHCORPORATION.NET	21.00

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

Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/19/2022 12:59 pm

		Part B Date 4.00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4.(see Instructions.)				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
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.				16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:				17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.				18.00
			3.00		
	Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CFO		19.00
20.00	Enter the employer/company name of the cost report preparer.				20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				21.00

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

Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/19/2022 12:59 pm

	Component	Number of Beds	Bed Days Available	Inpatient Days/Visits Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	84	30,660	0	3,023	15,891	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
6.10	SNF-Based CORF						6.10
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	84	30,660	0	3,023	15,891	8.00

	Component	Inpatient Days/Visits Other	Total	Discharges Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	4,520	23,434	0	68	35	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST	0	0				4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
6.10	SNF-Based CORF						6.10
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	4,520	23,434	0	68	35	8.00

	Component	Discharges Other	Total	Average Length of Stay Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	42	145	0.00	44.46	454.03	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
6.10	SNF-Based CORF						6.10
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	42	145	0.00	44.46	454.03	8.00

	Component	Average Length of Stay Total	Admissions Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
1.00	SKILLED NURSING FACILITY	161.61	0	72	22	53	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
6.10	SNF-Based CORF						6.10
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	161.61	0	72	22	53	8.00

	Component	Admissions Total	Full Time Equivalent Employees on Payroll	Nonpaid Workers		
		21.00	22.00	23.00		
1.00	SKILLED NURSING FACILITY	147	75.62	0.00		1.00
2.00	NURSING FACILITY	0	0.00	0.00		2.00
3.00	ICF/IID	0	0.00	0.00		3.00
4.00	HOME HEALTH AGENCY COST		0.00	0.00		4.00
5.00	Other Long Term Care	0	0.00	0.00		5.00
6.00	SNF-Based CMHC		0.00	0.00		6.00
6.10	SNF-Based CORF		0.00	0.00		6.10
7.00	HOSPICE	0	0.00	0.00		7.00
8.00	Total (Sum of lines 1-7)	147	75.62	0.00		8.00

SNF WAGE INDEX INFORMATION | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/19/2022 12:59 pm

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - DIRECT SALARIES						
	SALARIES						
1.00	Total salaries (See Instructions)	3,333,624	0	3,333,624	157,290.87	21.19	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	3,333,624	0	3,333,624	157,290.87	21.19	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
9.10	CORF						9.10
10.00	HOSPICE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	3,333,624	0	3,333,624	157,290.87	21.19	13.00
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	38,932	0	38,932	778.64	50.00	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	639,253	0	639,253			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	639,253	0	639,253			22.00

SNF WAGE INDEX INFORMATION | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part III Date/Time Prepared: 5/19/2022 12:59 pm

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	393,170	0	393,170	15,204.38	25.86	2.00
3.00	Plant Operation, Maintenance & Repairs	92,577	0	92,577	3,988.60	23.21	3.00
4.00	Laundry & Linen Service	37,329	0	37,329	3,065.14	12.18	4.00
5.00	Housekeeping	128,612	0	128,612	9,385.39	13.70	5.00
6.00	Dietary	273,215	0	273,215	18,048.69	15.14	6.00
7.00	Nursing Administration	262,958	0	262,958	6,179.57	42.55	7.00
8.00	Central Services and Supply	34,420	0	34,420	2,086.46	16.50	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	58,792	0	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	0	1,350,557	64,038.11	21.09	14.00

SNF WAGE RELATED COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part IV Date/Time Prepared: 5/19/2022 12:59 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	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
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	228,233	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	192,001	17.00
18.00	Medicare Taxes - Employers Portion Only	35,721	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	48,688	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	676,055	24.00

		Amount Reported	
		1.00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part V | Date/Time Prepared: 5/19/2022 12:59 pm

	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	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 Assistant/Nursing Assistants/Aides	968,418	80,405	1,048,823	57,002.46	18.40	3.00
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	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	0		0	0.00	0.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	0		0	0.00	0.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	0		0	0.00	0.00	17.00
18.00	Physical Therapists	154,032		154,032	2,232.34	69.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	143,501		143,501	2,079.72	69.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	128,693		128,693	1,865.12	69.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-7 | Date/Time Prepared: 5/19/2022 12:59 pm

		Group	Days	
		1.00	2.00	
1.00		RUX		1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00		RVL		4.00
5.00		RHX		5.00
6.00		RHL		6.00
7.00		RMX		7.00
8.00		RML		8.00
9.00		RLX		9.00
10.00		RUC		10.00
11.00		RUB		11.00
12.00		RUA		12.00
13.00		RVC		13.00
14.00		RVB		14.00
15.00		RVA		15.00
16.00		RHC		16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21.00		RMA		21.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00		ES3		24.00
25.00		ES2		25.00
26.00		ES1		26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30.00		HD1		30.00
31.00		HC2		31.00
32.00		HC1		32.00
33.00		HB2		33.00
34.00		HB1		34.00
35.00		LE2		35.00
36.00		LE1		36.00
37.00		LD2		37.00
38.00		LD1		38.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00		CE2		43.00
44.00		CE1		44.00
45.00		CD2		45.00
46.00		CD1		46.00
47.00		CC2		47.00
48.00		CC1		48.00
49.00		CB2		49.00
50.00		CB1		50.00
51.00		CA2		51.00
52.00		CA1		52.00
53.00		SE3		53.00
54.00		SE2		54.00
55.00		SE1		55.00
56.00		SSC		56.00
57.00		SSB		57.00
58.00		SSA		58.00
59.00		IB2		59.00
60.00		IB1		60.00
61.00		IA2		61.00
62.00		IA1		62.00
63.00		BB2		63.00
64.00		BB1		64.00
65.00		BA2		65.00
66.00		BA1		66.00
67.00		PE2		67.00
68.00		PE1		68.00
69.00		PD2		69.00
70.00		PD1		70.00
71.00		PC2		71.00
72.00		PC1		72.00
73.00		PB2		73.00
74.00		PB1		74.00
75.00		PA2		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet S-7 Date/Time Prepared: 5/19/2022 12:59 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		80,396	80,396	0	80,396	1.00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT		44,795	44,795	0	44,795	2.00
3.00	00300	EMPLOYEE BENEFITS	0	0	0	0	0	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	393,170	1,664,787	2,057,957	0	2,057,957	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	92,577	362,276	454,853	0	454,853	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	37,329	29,886	67,215	0	67,215	6.00
7.00	00700	HOUSEKEEPING	128,612	65,657	194,269	0	194,269	7.00
8.00	00800	DIETARY	273,215	301,564	574,779	0	574,779	8.00
9.00	00900	NURSING ADMINISTRATION	262,958	851,367	1,114,325	0	1,114,325	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	34,420	14,792	49,212	0	49,212	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	24,381	24,381	0	24,381	12.00
13.00	01300	SOCIAL SERVICE	58,792	17,043	75,835	0	75,835	13.00
15.00	01500	OTHER GENERAL SERVICES	69,484	16,814	86,298	0	86,298	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	1,983,067	0	1,983,067	0	1,983,067	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	154,032	154,032	0	154,032	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	143,501	143,501	0	143,501	45.00
46.00	04600	SPEECH PATHOLOGY	0	128,693	128,693	0	128,693	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	167,627	167,627	0	167,627	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	99,865	99,865	0	99,865	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE		0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	3,333,624	4,167,476	7,501,100	0	7,501,100	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
100.00		TOTAL	3,333,624	4,167,476	7,501,100	0	7,501,100	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	0	80,396		1.00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT	0	44,795		2.00
3.00	00300	EMPLOYEE BENEFITS	0	0		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	2,057,957		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	454,853		5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	67,215		6.00
7.00	00700	HOUSEKEEPING	0	194,269		7.00
8.00	00800	DIETARY	0	574,779		8.00
9.00	00900	NURSING ADMINISTRATION	0	1,114,325		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	49,212		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	24,381		12.00
13.00	01300	SOCIAL SERVICE	0	75,835		13.00
15.00	01500	OTHER GENERAL SERVICES	0	86,298		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	1,983,067		30.00
31.00	03100	NURSING FACILITY	0	0		31.00
32.00	03200	ICF/IID	0	0		32.00
33.00	03300	OTHER LONG TERM CARE	0	0		33.00
		ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	0		40.00
41.00	04100	LABORATORY	0	0		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0		43.00
44.00	04400	PHYSICAL THERAPY	0	154,032		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	143,501		45.00
46.00	04600	SPEECH PATHOLOGY	0	128,693		46.00
47.00	04700	ELECTROCARDIOLOGY	0	0		47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	167,627		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	99,865		49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0		52.00
		OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	0		60.00
61.00	06100	RURAL HEALTH CLINIC	0	0		61.00
62.00	06200	FQHC				62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0		63.00
		OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	0		70.00
71.00	07100	AMBULANCE	0	0		71.00
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	0	0		80.00
81.00	08100	INTEREST EXPENSE	0	0		81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0		82.00
83.00	08300	HOSPICE	0	0		83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0		84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	7,501,100		89.00
		NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0		91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0		93.00
94.00	09400	PATIENTS' LAUNDRY	0	0		94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0		95.00
100.00		TOTAL	0	7,501,100		100.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 | Date/Time Prepared: 5/19/2022 12:59 pm

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	200,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,824,000	0	0	0	0	3.00
4.00	Building Improvements	1,456,756	19,657	0	19,657	0	4.00
5.00	Fixed Equipment	175,158	0	0	0	0	5.00
6.00	Movable Equipment	647,550	12,785	0	12,785	0	6.00
7.00	Subtotal (sum of lines 1-6)	4,303,464	32,442	0	32,442	0	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	4,303,464	32,442	0	32,442	0	9.00

	Description	Ending Balance	Fully Depreciated 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

ADJUSTMENTS TO EXPENSES | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/19/2022 12:59 pm

	Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line No.	
		1.00	2.00	3.00	4.00	
1.00	Investment income on restricted funds (chapter 2)		0		0.00	1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3.00
4.00	Rental of provider space by suppliers (chapter 8)		0		0.00	4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	5.00
6.00	Television and radio service (chapter 21)		0		0.00	6.00
7.00	Parking lot (chapter 21)		0		0.00	7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00	Home office cost (chapter 21)		0		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00	11.00
12.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals		0		0.00	14.00
15.00	Cost of meals - Guests		0		0.00	15.00
16.00	Sale of medical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Vending machines		0		0.00	19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF	82.00	22.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00	Depreciation--movable equipment		0	CAP REL COSTS - MOVEABLE EQUIPMENT	2.00	24.00
25.00	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)		0			100.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 Parts I-II | Date/Time Prepared: 5/19/2022 12:59 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		4.00	ADMINISTRATIVE & GENERAL	HOME OFFICE MGMT FEES	1.00
2.00		30.00	SKILLED NURSING FACILITY	MEDICAL SUPPLIES	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 6, line 100 to Worksheet A-8, column 3, line 12.				10.00

		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)		
		4.00	5.00	6.00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		420,439	420,439	0		1.00
2.00		14,566	14,566	0		2.00
3.00		0	0	0		3.00
4.00		0	0	0		4.00
5.00		0	0	0		5.00
6.00		0	0	0		6.00
7.00		0	0	0		7.00
8.00		0	0	0		8.00
9.00		0	0	0		9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	435,005	435,005	0		10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-1 Parts I-II Date/Time Prepared: 5/19/2022 12:59 pm

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
	The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.					
	This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.					
1.00		B	AMERICAN HEALTH	100.00		1.00
2.00		A	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) specify:			0.00		100.00
	(1) Use the following symbols to indicate interrelationship to related organizations:					
	A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.					
	B. Corporation, partnership, or other organization has financial interest in provider.					
	C. Provider has financial interest in corporation, partnership, or other organization.					
	D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.					
	E. Individual is director, officer, administrator, or key person of provider and related organization.					
	F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.					

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
	The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.				
	This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.				
1.00		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) specify:		0.00		100.00
	(1) Use the following symbols to indicate interrelationship to related organizations:				
	A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.				
	B. Corporation, partnership, or other organization has financial interest in provider.				
	C. Provider has financial interest in corporation, partnership, or other organization.				
	D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.				
	E. Individual is director, officer, administrator, or key person of provider and related organization.				
	F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.				

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDGS & FIXTURES	CAPITAL RELATED COSTS MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
			0	1.00	2.00	3.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	80,396	80,396				1.00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT	44,795		44,795			2.00
3.00	00300	EMPLOYEE BENEFITS	0	204	114	318		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	2,057,957	13,060	7,277	0	2,078,294	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	454,853	0	0	0	0	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	67,215	537	299	0	0	6.00
7.00	00700	HOUSEKEEPING	194,269	685	382	0	0	7.00
8.00	00800	DIETARY	574,779	11,958	6,662	0	0	8.00
9.00	00900	NURSING ADMINISTRATION	1,114,325	519	289	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	49,212	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	24,381	157	88	0	0	12.00
13.00	01300	SOCIAL SERVICE	75,835	500	279	0	0	13.00
15.00	01500	OTHER GENERAL SERVICES	86,298	0	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	1,983,067	47,394	26,407	318	2,078,294	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	154,032	1,964	1,094	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	143,501	1,964	1,094	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	128,693	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,627	565	315	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	99,865	889	495	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	7,501,100	80,396	44,795	318	2,078,294	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	7,501,100	80,396	44,795	318	2,078,294	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200	CAP REL COSTS - 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					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	3,640	71,691				6.00
7.00	00700	HOUSEKEEPING	4,644	0	199,980			7.00
8.00	00800	DIETARY	81,018	0	36,281	710,698		8.00
9.00	00900	NURSING ADMINISTRATION	3,514	0	1,574	0	1,120,221	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	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	0	1,518	0	30,693	13.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	0	36,275	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	321,120	71,691	143,801	710,698	1,035,284	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	13,304	0	5,958	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	13,304	0	5,958	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,828	0	1,714	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	6,025	0	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	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	454,853	71,691	199,980	710,698	1,120,221	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	454,853	71,691	199,980	710,698	1,120,221	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	Subtotal	
			10.00	12.00	13.00	15.00	16.00	
		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	HOUSEKEEPING						7.00
8.00	00800	DIETARY						8.00
9.00	00900	NURSING ADMINISTRATION						9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	67,181					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	26,171				12.00
13.00	01300	SOCIAL SERVICE	1,871	0	114,085			13.00
15.00	01500	OTHER GENERAL SERVICES	2,211	0	0	124,784		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	63,099	26,171	102,452	112,060	6,721,856	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	4,245	4,643	185,240	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	4,245	4,643	174,709	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	128,693	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,221	1,336	176,606	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	1,922	2,102	113,996	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	67,181	26,171	114,085	124,784	7,501,100	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0			0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	67,181	26,171	114,085	124,784	7,501,100	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	Post Stepdown Adjustments	Total		
			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	HOUSEKEEPING				7.00
8.00	00800	DIETARY				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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	6,721,856		30.00
31.00	03100	NURSING FACILITY	0	0		31.00
32.00	03200	ICF/IID	0	0		32.00
33.00	03300	OTHER LONG TERM CARE	0	0		33.00
		ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	0		40.00
41.00	04100	LABORATORY	0	0		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0		43.00
44.00	04400	PHYSICAL THERAPY	0	185,240		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	174,709		45.00
46.00	04600	SPEECH PATHOLOGY	0	128,693		46.00
47.00	04700	ELECTROCARDIOLOGY	0	0		47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	176,606		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	113,996		49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0		52.00
		OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	0		60.00
61.00	06100	RURAL HEALTH CLINIC	0	0		61.00
62.00	06200	FQHC				62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0		63.00
		OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	0		70.00
71.00	07100	AMBULANCE	0	0		71.00
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	INTEREST EXPENSE				81.00
82.00	08200	UTILIZATION REVIEW - SNF				82.00
83.00	08300	HOSPICE	0	0		83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0		84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	7,501,100		89.00
		NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0		91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0		93.00
94.00	09400	PATIENTS' LAUNDRY	0	0		94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0		95.00
98.00		Cross Foot Adjustments	0	0		98.00
99.00		Negative Cost Centers	0	0		99.00
100.00		TOTAL	0	7,501,100		100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDGS & FIXTURES	CAPITAL RELATED COSTS MOVEABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	3.00	
		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	0	204	114	318	318	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	13,060	7,277	20,337	0	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	0	0	0	0	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	537	299	836	0	6.00
7.00	00700	HOUSEKEEPING	0	685	382	1,067	0	7.00
8.00	00800	DIETARY	0	11,958	6,662	18,620	0	8.00
9.00	00900	NURSING ADMINISTRATION	0	519	289	808	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	157	88	245	0	12.00
13.00	01300	SOCIAL SERVICE	0	500	279	779	0	13.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	0	47,394	26,407	73,801	318	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	1,964	1,094	3,058	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	1,964	1,094	3,058	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	565	315	880	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	889	495	1,384	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	80,396	44,795	125,191	318	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments				0		98.00
99.00		Negative Cost Centers		0	0	0	0	99.00
100.00		TOTAL	0	80,396	44,795	125,191	318	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			4.00	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200	CAP REL COSTS - 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	0				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	836			6.00
7.00	00700	HOUSEKEEPING	0	0	0	1,067		7.00
8.00	00800	DIETARY	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	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	3	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	8	0	13.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	20,337	0	836	767	18,814	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	32	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	32	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	14	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	20,337	0	836	1,067	18,814	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments			0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	20,337	0	836	1,067	18,814	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	
			9.00	10.00	12.00	13.00	15.00	
		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	HOUSEKEEPING						7.00
8.00	00800	DIETARY						8.00
9.00	00900	NURSING ADMINISTRATION	816					9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	13	13				10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	248			12.00
13.00	01300	SOCIAL SERVICE	22	0	0	809		13.00
15.00	01500	OTHER GENERAL SERVICES	26	0	0	0	26	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	755	13	248	726	24	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	30	1	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	30	1	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	14	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	816	13	248	809	26	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0			0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	816	13	248	809	26	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	Subtotal	Post Step-Down Adjustments	Total		
			16.00	17.00	18.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE					6.00
7.00	00700	HOUSEKEEPING					7.00
8.00	00800	DIETARY					8.00
9.00	00900	NURSING ADMINISTRATION					9.00
10.00	01000	CENTRAL SERVICES & SUPPLY					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY					12.00
13.00	01300	SOCIAL SERVICE					13.00
15.00	01500	OTHER GENERAL SERVICES					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	116,639	0	116,639		30.00
31.00	03100	NURSING FACILITY	0	0	0		31.00
32.00	03200	ICF/IID	0	0	0		32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	0	0		40.00
41.00	04100	LABORATORY	0	0	0		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0		43.00
44.00	04400	PHYSICAL THERAPY	3,121	0	3,121		44.00
45.00	04500	OCCUPATIONAL THERAPY	3,121	0	3,121		45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0		46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0		47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	898	0	898		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	1,412	0	1,412		49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0		50.00
51.00	05100	SUPPORT SURFACES	0	0	0		51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0		52.00
		OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	0		60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0		61.00
62.00	06200	FQHC					62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0		63.00
		OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	0		70.00
71.00	07100	AMBULANCE	0	0	0		71.00
72.00	07200	CORF	0	0	0		72.00
73.00	07300	CMHC	0	0	0		73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0		74.00
		SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0		83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0		84.00
89.00		SUBTOTALS (sum of lines 1-84)	125,191	0	125,191		89.00
		NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0		91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0	0		93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0		94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0		95.00
98.00		Cross Foot Adjustments	0	0	0		98.00
99.00		Negative Cost Centers	0	0	0		99.00
100.00		TOTAL	125,191	0	125,191		100.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDGS & FIXTURES (SQUARE FEET)	MOVEABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (TOTAL PATIENT DAYS)	ADMINISTRATIVE & GENERAL (TOTAL PATIENT DAYS)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	8,680					1.00
2.00	00200	CAP REL COSTS - MOVEABLE EQUIPMENT		8,680				2.00
3.00	00300	EMPLOYEE BENEFITS	22	22	23,434			3.00
4.00	00400	ADMINISTRATIVE & GENERAL	1,410	1,410	0	23,434		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	0	0	0	7,248	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	58	58	0	0	58	6.00
7.00	00700	HOUSEKEEPING	74	74	0	0	74	7.00
8.00	00800	DIETARY	1,291	1,291	0	0	1,291	8.00
9.00	00900	NURSING ADMINISTRATION	56	56	0	0	56	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	17	17	0	0	17	12.00
13.00	01300	SOCIAL SERVICE	54	54	0	0	54	13.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	5,117	5,117	23,434	23,434	5,117	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	212	212	0	0	212	44.00
45.00	04500	OCCUPATIONAL THERAPY	212	212	0	0	212	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	61	61	0	0	61	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	96	96	0	0	96	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	8,680	8,680	23,434	23,434	7,248	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	80,396	44,795	318	2,078,294	454,853	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	9.262212	5.160714	0.013570	88.687121	62.755657	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)			318	20,337	0	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)			0.013570	0.867842	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (GROSS SALARIES)	
			6.00	7.00	8.00	9.00	10.00	
		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	23,434					6.00
7.00	00700	HOUSEKEEPING	0	7,116				7.00
8.00	00800	DIETARY	0	1,291	23,434			8.00
9.00	00900	NURSING ADMINISTRATION	0	56	0	2,145,763		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	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	0	58,792	58,792	13.00
15.00	01500	OTHER GENERAL SERVICES	0	0	0	69,484	69,484	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
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	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	212	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	212	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	96	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0		0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	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	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	23,434	7,116	23,434	2,145,763	2,111,343	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	71,691	199,980	710,698	1,120,221	67,181	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	3.059273	28.102867	30.327644	0.522062	0.031819	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	836	1,067	18,814	816	13	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.035675	0.149944	0.802851	0.000380	0.000006	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (SQUARE FEET)	OTHER GENERAL SERVICE S (SQUARE FEET)		
			12.00	13.00	15.00		
		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	HOUSEKEEPING					7.00
8.00	00800	DIETARY					8.00
9.00	00900	NURSING ADMINISTRATION					9.00
10.00	01000	CENTRAL SERVICES & SUPPLY					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	23,434				12.00
13.00	01300	SOCIAL SERVICE	0	5,698			13.00
15.00	01500	OTHER GENERAL SERVICES	0	0	5,698		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	23,434	5,117	5,117		30.00
31.00	03100	NURSING FACILITY	0	0	0		31.00
32.00	03200	ICF/IID	0	0	0		32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	0	0		40.00
41.00	04100	LABORATORY	0	0	0		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0		43.00
44.00	04400	PHYSICAL THERAPY	0	212	212		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	212	212		45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0		46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0		47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61	61		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	96	96		49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0		50.00
51.00	05100	SUPPORT SURFACES	0	0	0		51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0		52.00
		OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	0		60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0		61.00
62.00	06200	FQHC					62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0		63.00
		OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	0		70.00
71.00	07100	AMBULANCE	0	0	0		71.00
72.00	07200	CORF	0	0	0		72.00
73.00	07300	CMHC	0	0	0		73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0		74.00
		SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0		83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0		84.00
89.00		SUBTOTALS (sum of lines 1-84)	23,434	5,698	5,698		89.00
		NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0		91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0	0		93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0		94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0		95.00
98.00		Cross Foot Adjustments					98.00
99.00		Negative Cost Centers					99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	26,171	114,085	124,784		102.00
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, Part II)	248	809	26		104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.010583	0.141980	0.004563		105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C | Date/Time Prepared: 5/19/2022 12:59 pm

		Cost Center Description	Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2	
			1.00	2.00	3.00	
		ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	0	0.000000	40.00
41.00	04100	LABORATORY	0	0	0.000000	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	185,240	305,915	0.605528	44.00
45.00	04500	OCCUPATIONAL THERAPY	174,709	321,919	0.542711	45.00
46.00	04600	SPEECH PATHOLOGY	128,693	267,840	0.480485	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	176,606	5,230	33.767878	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	113,996	87,673	1.300241	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	10,757	0.000000	52.00
		OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FQHC				62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0.000000	63.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	779,244	999,334		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/19/2022 12:59 pm
	Title XVIII (1)	Skilled Nursing Facility	PPS

		Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost		
				Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
			1.00	2.00	3.00	4.00	5.00	
		PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST						
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0.000000	0	0	0	0	40.00
41.00	04100	LABORATORY	0.000000	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.605528	249,920	0	151,334	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.542711	236,107	0	128,138	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.480485	151,805	0	72,940	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	33.767878	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	1.300241	83,639	0	108,751	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0.000000	0		0		50.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0.000000	9,297	0	0	0	52.00
		OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0.000000	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC						61.00
62.00	06200	FQHC						62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	63.00
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		730,768	0	461,163	0	100.00

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

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

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Prepared: 5/19/2022 12:59 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description		
			1.00	
		PART II - APPORTIONMENT OF VACCINE COST		
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.300241	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	0	3.00

		Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH						
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	0	0	0.000000	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	185,240	0	0.000000	151,334	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	174,709	0	0.000000	128,138	0	45.00
46.00	04600	SPEECH PATHOLOGY	128,693	0	0.000000	72,940	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	176,606	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	113,996	0	0.000000	108,751	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0.000000	0	0	52.00
100.00		Total (Sum of lines 40 - 52)	779,244	0		461,163	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Prepared: 5/19/2022 12:59 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS		
	INPATIENT DAYS		
1.00	Inpatient days including private room days	23,434	1.00
2.00	Private room days	1,625	2.00
3.00	Inpatient days including private room days applicable to the Program	3,023	3.00
4.00	Medically necessary private room days applicable to the Program	1,625	4.00
5.00	Total general inpatient routine service cost	6,721,856	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	6,146,902	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	1.093536	7.00
8.00	Enter private room charges from your records	457,590	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	281.59	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	281.59	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	307.93	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	500,386	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	6,221,470	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	265.49	16.00
17.00	Program routine service cost (Line 3 times line 16)	802,576	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	500,386	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	1,302,962	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	116,639	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	4.98	21.00
22.00	Program capital related cost (Line 3 times line 21)	15,055	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,287,907	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,287,907	25.00
26.00	Enter the per diem limitation (1)		26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00

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

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	23,434	1.00
2.00	Program inpatient days (see instructions)	3,023	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)	0.129001	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Prepared: 5/19/2022 12:59 pm
	Title XIX	Skilled Nursing Facility	

		1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS		
	INPATIENT DAYS		
1.00	Inpatient days including private room days	23,434	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	15,891	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	6,721,856	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	0	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.000000	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	6,721,856	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	286.84	16.00
17.00	Program routine service cost (Line 3 times line 16)	4,558,174	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	4,558,174	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	116,639	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	4.98	21.00
22.00	Program capital related cost (Line 3 times line 21)	79,137	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	4,479,037	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	4,479,037	25.00
26.00	Enter the per diem limitation (1)	0.00	26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	0	27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)	4,558,174	28.00

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

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Prepared: 5/19/2022 12:59 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
1.00	Inpatient PPS amount (See Instructions)	1,651,873	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)	0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	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 instructions)	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	Tentative adjustment	0	13.00
14.00	OTHER adjustment (See instructions)	0	14.00
14.50	Demonstration payment adjustment amount before sequestration	0	14.50
14.55	Demonstration payment adjustment amount after sequestration	0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)	0	14.75
14.99	Sequestration amount (see instructions)	0	14.99
15.00	Balance due provider/program (see Instructions)	13,824	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY		
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	0	19.00
20.00	Medicare Part B ancillary charges (See instructions)	0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	0	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0	25.00
26.00	Interim payments (See instructions)	0	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	0	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Prepared: 5/19/2022 12:59 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,444,298		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		1,444,298		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		13,824		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,458,122		0	7.00

		Contractor Name	Contractor Number	
		1.00	2.00	
8.00	Name of Contractor			8.00

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

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

Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/19/2022 12:59 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	Assets					
	CURRENT ASSETS					
1.00	Cash on hand and in banks	316,557	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	418,921	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-14	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	61,843	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	797,307	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	200,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,824,000	0	0	0	15.00
16.00	Less Accumulated depreciation	-1,679,595	0	0	0	16.00
17.00	Leasehold improvements	1,456,756	0	0	0	17.00
18.00	Less: Accumulated Amortization	-674,481	0	0	0	18.00
19.00	Fixed equipment	175,158	0	0	0	19.00
20.00	Less: Accumulated depreciation	-169,286	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	647,550	0	0	0	23.00
24.00	Less: Accumulated depreciation	-563,685	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1,216,417	0	0	0	28.00
	OTHER ASSETS					
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	4,776,218	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	4,776,218	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	6,789,942	0	0	0	34.00
	Liabilities and Fund Balances					
	CURRENT LIABILITIES					
35.00	Accounts payable	250,862	0	0	0	35.00
36.00	Salaries, wages, and fees payable	321,766	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0				40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	738,792	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1,311,420	0	0	0	43.00
	LONG TERM LIABILITIES					
44.00	Mortgage payable	4,771,266	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	COVID EXCHANGE	569,233	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	5,340,499	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	6,651,919	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	138,023				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	138,023	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	6,789,942	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/19/2022 12:59 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		313,465		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-175,442				2.00
3.00	Total (sum of line 1 and line 2)		138,023		0		3.00
4.00	Additions (credit adjustments)						4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		138,023		0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		138,023		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider No.: 315014 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I-II | Date/Time Prepared: 5/19/2022 12:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Care Services				
1.00	SKILLED NURSING FACILITY	6,146,902		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)	6,146,902		6,146,902	5.00
	All Other Care Services				
6.00	ANCILLARY SERVICES	999,335	0	999,335	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
11.10	CORF		0	0	11.10
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	7,146,237	0	7,146,237	14.00

	Cost Center Description			
		1.00	2.00	
	PART II - OPERATING EXPENSES			
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		7,501,100	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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315014	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/19/2022 12:59 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	7,146,237	1.00
2.00	Less: contractual allowances and discounts on 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 Worksheet G-2, Part II, line 15)	7,501,100	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-733,116	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	557,674	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	557,674	25.00
26.00	Total (Line 5 plus line 25)	-175,442	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-175,442	31.00