

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: 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I, II & III Date/Time Prepared: 11/23/2021 9:23 am
---	----------------------	---	---

PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date:	Time:
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Contractor No. <u>12001</u>	7. <input type="checkbox"/> First Cost Report for this Provider CCN
	5. Date Received: <u>11/17/2021</u>	8. <input type="checkbox"/> Last Cost Report for this Provider CCN	9. NPR Date: <u>01/04/2022</u>
		10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened	11. Contractor Vendor Code <u>4</u>
		12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BRISTOL GLEN ( 315439 ) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

	Title V	Title XVIII		Title XIX	
		Part A	Part B		
	1.00	2.00	3.00	4.00	
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00	SKILLED NURSING FACILITY	0	1,663	0	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID			0	3.00
4.00	SNF - BASED HHA I	0	0	0	4.00
5.00	SNF - BASED RHC I	0		0	5.00
6.00	SNF - BASED FQHC I	0		0	6.00
7.00	SNF - BASED CMHC I	0		0	7.00
100.00	TOTAL	0	1,663	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete and review the information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 9:23 am			
1.00		2.00		3.00			
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:							
1.00	Street: 200 BRI STOL GLEN DRIVE	PO Box:				1.00	
2.00	City: NEWTON	State: NJ	Zip Code: 07860			2.00	
3.00	County: SUSSEX	CBSA Code: 35084	Urban/Rural: U			3.00	
3.01		CBSA Code:				3.01	
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)		
		1.00	2.00	3.00	V	XVIII	XIX
				4.00	5.00	6.00	
SNF and SNF-Based Component Identification:							
4.00	SNF	BRI STOL GLEN	315439	02/19/1998	N	P	0
5.00	Nursing Facility						
6.00	ICF/IID						
7.00	SNF-Based HHA						
8.00	SNF-Based RHC						
9.00	SNF-Based FOHC						
10.00	SNF-Based CMHC						
11.00	SNF-Based OLTC						
12.00	SNF-Based HOSPICE						
13.00	SNF-Based CORF						
				From:	To:		
				1.00	2.00		
14.00	Cost Reporting Period (mm/dd/yyyy)			07/01/2020	06/30/2021		14.00
15.00	Type of Control (See Instructions)			1			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	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	
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	
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	
19.01	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	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.							
20.00	Straight Line					1,769,473	
21.00	Declining Balance					0	
22.00	Sum of the Year's Digits					0	
23.00	Sum of line 20 through 22					1,769,473	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					Y	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	
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	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	
				Part A	Part B	Other	
				1.00	2.00	3.00	
29.00	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.					N	
30.00	Skilled Nursing Facility					N	
31.00	Nursing Facility					N	
32.00	ICF/IID					N	
33.00	SNF-Based HHA					N	
34.00	SNF-Based RHC					N	
35.00	SNF-Based FOHC					N	
36.00	SNF-Based CMHC					N	
36.00	SNF-Based OLTC					N	
				Y/N			
				1.00			
				2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N	
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	
			Premiums	Paid Losses	Self Insurance		
			1.00	2.00	3.00		
41.00	List malpractice premiums and paid losses:		75,623	0	0		41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 9:23 am
--	-----------------------	---	--

		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.	H53010	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: UNITED METHODIST HOMES OF NJ	Contractor's Name: UNITED METHODIST HOMES OF NJ	Contractor's Number: 12001
46.00	Street: 3311 HIGHWAY 33	PO Box:	
47.00	City: NEPTUNE	State: NJ	Zip Code: 07753

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 9:23 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	10/25/2021	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.	Y			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.)	Y	10/13/2021	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.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

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

Provider No. : 315439

Period:  
 From 07/01/2020  
 To 06/30/2021

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 11/23/2021 9:23 am

		1.00	2.00	
<b>Cost Report Preparer Contact Information</b>				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DEANDRA	FALLON	19.00
20.00	Enter the employer/company name of the cost report preparer.	BAKER TILLY US, LLP		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	570-820-0301	DEANDRA.FALLON@BAKERTILLY.COM	21.00

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

Provider No. : 315439

Period:  
 From 07/01/2020  
 To 06/30/2021

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 11/23/2021 9:23 am

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA, SENIOR MANAGER	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

VOLUNTARY CONTACT INFORMATION

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet S-2  
Part V  
Date/Time Prepared:  
11/23/2021 9:23 am

		1.00	
<b>Cost Report Preparer Contact Information</b>			
1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer		4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1		8.00
9.00	Mailing Address 2		9.00
10.00	City		10.00
11.00	State		11.00
12.00	Zip		12.00
<b>Officer or Administrator of Provider Contact Information</b>			
13.00	First Name	DEANDRA	13.00
14.00	Last Name	FALLON	14.00
15.00	Title		15.00
16.00	Employer		16.00
17.00	Phone Number	5708200100	17.00
18.00	E-mail Address	Deandra.Fallon@bakertilly.com	18.00
19.00	Department		19.00
20.00	Mailing Address 1	46 PUBLIC SQ., STE 400	20.00
21.00	Mailing Address 2		21.00
22.00	City	WILKES-BARRE	22.00
23.00	State	PA	23.00
24.00	Zip	18701	24.00

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

Provider No. : 315439

Period:  
 From 07/01/2020  
 To 06/30/2021

Worksheet S-3  
 Part I  
 Date/Time Prepared:  
 11/23/2021 9:23 am

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	60	21,900	0	2,302	4,769	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	138	50,370				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	198	72,270	0	2,302	4,769	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	8,898	15,969	0	126	5	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	25,478	25,478				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	34,376	41,447	0	126	5	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	94	225	0.00	18.27	953.80	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	78	78				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	172	303	0.00	18.27	953.80	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX		Other
		16.00	17.00	18.00	19.00		20.00
1.00	SKILLED NURSING FACILITY	70.97	0	132	16	68	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	326.64				49	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	136.79	0	132	16	117	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	216	42.35	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	49	38.79	0.00	5.00		
6.00	SNF-Based CMHC		0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	265	81.14	0.00	8.00		



Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/23/2021 9:23 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - DIRECT SALARIES</b>						
<b>SALARIES</b>						
1.00	Total salaries (See Instructions)	7,853,992	0	7,853,992	332,531.00	23.62 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)	7,853,992	0	7,853,992	332,531.00	23.62 6.00
7.00	Other Long Term Care	1,914,619	0	1,914,619	80,674.00	23.73 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	39,441	0	39,441	2,683.00	14.70 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	1,954,060	0	1,954,060	83,357.00	23.44 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	5,899,932	0	5,899,932	249,174.00	23.68 13.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	171,590	0	171,590	3,694.00	46.45 14.00
15.00	Contract Labor: Physician services-Part A	24,000	0	24,000	104.00	230.77 15.00
16.00	Home office salaries & wage related costs	859,225	0	859,225	14,783.00	58.12 16.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	2,097,883	0	2,097,883		
18.00	Wage-related costs other (See Part IV)	3,697	0	3,697		
19.00	Wage related costs (excluded units)	522,870	0	522,870		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	1,578,710	0	1,578,710		

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/23/2021 9:23 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - OVERHEAD COST - DIRECT SALARIES</b>						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	1,120,877	0	1,120,877	29,982.00	2.00
3.00	Plant Operation, Maintenance & Repairs	325,914	0	325,914	19,128.00	3.00
4.00	Laundry & Linen Service	62,738	0	62,738	2,497.00	4.00
5.00	Housekeeping	448,713	0	448,713	31,281.00	5.00
6.00	Dietary	799,659	0	799,659	51,428.00	6.00
7.00	Nursing Administration	0	0	0.00	0.00	7.00
8.00	Central Services and Supply	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0.00	0.00	10.00
11.00	Social Service	37,593	0	37,593	1,593.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	277,107	0	277,107	16,973.00	13.00
14.00	Total (sum lines 1 thru 13)	3,072,601	0	3,072,601	152,882.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/23/2021 9:23 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		126,142	3.00
4.00	Prior Year Pension Service Cost		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		1,018,761	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		12,372	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)		4,035	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		277,948	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		566,584	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		88,913	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		3,128	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		2,097,883	24.00
				Amount Reported
				1.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COST		3,697	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet S-3  
Part V  
Date/Time Prepared:  
11/23/2021 9:23 am

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	1,166,768	312,227	1,478,995	27,610.00	53.57	1.00
2.00	Licensed Practical Nurses (LPNs)	297,131	79,512	376,643	10,016.00	37.60	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	692,335	185,269	877,604	41,679.00	21.06	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,156,234	577,008	2,733,242	79,305.00	34.46	4.00
5.00	Physical Therapists	201,178	53,835	255,013	4,225.00	60.36	5.00
6.00	Physical Therapy Assistants	6,229	1,667	7,896	243.00	32.49	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	44,185	11,824	56,009	1,055.00	53.09	8.00
9.00	Occupational Therapy Assistants	52,031	13,924	65,955	1,374.00	48.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	22,497	6,020	28,517	405.00	70.41	11.00
12.00	Respiratory Therapists	31,466	8,420	39,886	893.00	44.67	12.00
13.00	Other Medical Staff	313,511	83,896	397,407	8,794.00	45.19	13.00
<b>Contract Labor</b>							
<b>Nursing Occupations</b>							
14.00	Registered Nurses (RNs)	19,720		19,720	329.00	59.94	14.00
15.00	Licensed Practical Nurses (LPNs)	44,525		44,525	809.00	55.04	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	107,345		107,345	2,556.00	42.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	171,590		171,590	3,694.00	46.45	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet S-7  
Date/Time Prepared:  
11/23/2021 9:23 am

		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. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet S-7

Date/Time Prepared:  
11/23/2021 9:23 am

		Group	Days	
76.00		1.00	2.00	
99.00		PA1		76.00
100.00	TOTAL	AAA		99.00
				100.00
		Expenses	Percentage	Y/N
		1.00	2.00	3.00
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)				
101.00	Staffing			101.00
102.00	Recruitment			102.00
103.00	Retention of employees			103.00
104.00	Training			104.00
105.00	OTHER (SPECIFY)			105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)			106.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		3,021,021	3,021,021	0	3,021,021	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300	0	2,101,580	2,101,580	0	2,101,580	3.00
4.00	00400	1,120,877	2,713,822	3,834,699	0	3,834,699	4.00
5.00	00500	325,914	1,359,773	1,685,687	0	1,685,687	5.00
6.00	00600	62,738	25,918	88,656	0	88,656	6.00
7.00	00700	448,713	81,175	529,888	0	529,888	7.00
8.00	00800	799,659	1,388,169	2,187,828	0	2,187,828	8.00
9.00	00900	0	0	0	0	0	9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	37,593	0	37,593	0	37,593	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	221,839	52,588	274,427	0	274,427	15.00
15.01	01501	55,268	659	55,927	0	55,927	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,469,745	436,384	2,906,129	0	2,906,129	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	1,914,619	87,936	2,002,555	0	2,002,555	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	6,939	6,939	0	6,939	40.00
41.00	04100	0	46,425	46,425	0	46,425	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	31,466	20,349	51,815	0	51,815	43.00
44.00	04400	207,407	141,232	348,639	-121,722	226,917	44.00
45.00	04500	96,216	0	96,216	105,936	202,152	45.00
46.00	04600	22,497	0	22,497	15,786	38,283	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	10,153	10,153	0	10,153	48.00
49.00	04900	0	145,317	145,317	0	145,317	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000	0	0	0	0	0	80.00
81.00	08100	0	0	0	0	0	81.00
82.00	08200	0	0	0	0	0	82.00
83.00	08300	0	0	0	0	0	83.00
89.00		7,814,551	11,639,440	19,453,991	0	19,453,991	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	39,441	16,388	55,829	0	55,829	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
100.00		7,853,992	11,655,828	19,509,820	0	19,509,820	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-1,049,069	1,971,952	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	-46,315	2,055,265	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-728,728	3,105,971	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	-62,942	1,622,745	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	-1,909	86,747	6.00
7.00	00700	HOUSEKEEPING	0	529,888	7.00
8.00	00800	DIETARY	-29,869	2,157,959	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	37,593	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	274,427	15.00
15.01	01501	CHAPLAIN	0	55,927	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	0	2,906,129	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	2,002,555	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	0	6,939	40.00
41.00	04100	LABORATORY	0	46,425	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	51,815	43.00
44.00	04400	PHYSICAL THERAPY	0	226,917	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	202,152	45.00
46.00	04600	SPEECH PATHOLOGY	0	38,283	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,153	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	145,317	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
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
89.00		SUBTOTALS (sum of lines 1-84)	-1,918,832	17,535,159	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	55,829	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	NON-REIMBURSABLE	0	0	95.00
100.00		TOTAL	-1,918,832	17,590,988	100.00



RECLASSIFICATIONS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A-6

Date/Time Prepared:  
11/23/2021 9:23 am

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
	(1) A - TO RECLASS OT AND ST FROM PT					
1.00		OCCUPATIONAL THERAPY	45.00	46,887	59,049	1.00
2.00		SPEECH PATHOLOGY	46.00	6,987	8,799	2.00
	TOTALS					
100.00		Total Recl assi fi cations (Sum of col umns 4 and 5 must equal sum of col umns 8 and 9)		53,874	67,848	100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.  
 (2) Transfer to Worksheet A, col. 5, line as appropriate.

RECLASSIFICATIONS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A-6

Date/Time Prepared:  
11/23/2021 9:23 am

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	(1) A - TO RECLASS OT AND ST FROM PT					
1.00		PHYSICAL THERAPY	44.00	53,874	67,848	1.00
2.00			0.00	0	0	2.00
	TOTALS			53,874	67,848	100.00
100.00						

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.  
 (2) Transfer to Worksheet A, col. 5, line as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A-7

Date/Time Prepared:  
11/23/2021 9:23 am

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	2,319,707	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	51,255,892	7,254,741	0	7,254,741	7,417	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	3,024,169	756,306	0	756,306	5,440	5.00
6.00 Movable Equipment	117,127	0	0	0	0	6.00
7.00 Subtotal (sum of lines 1-6)	56,716,895	8,011,047	0	8,011,047	12,857	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	56,716,895	8,011,047	0	8,011,047	12,857	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	2,319,707	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	58,503,216	0				
4.00 Building Improvements	0	0				
5.00 Fixed Equipment	3,775,035	0				
6.00 Movable Equipment	117,127	0				
7.00 Subtotal (sum of lines 1-6)	64,715,085	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	64,715,085	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A-8

Date/Time Prepared:  
11/23/2021 9:23 am

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
1.00 Investment income on restricted funds (chapter 2)	B	-1,024,561	CAP REL COSTS - BLDGS & FIXTURES		1.00 1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 2.00
3.00 Refunds and rebates of expenses (chapter 8)		0			0.00 3.00
4.00 Rental of provider space by suppliers (chapter 8)	B	-13,000	CAP REL COSTS - BLDGS & FIXTURES		1.00 4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 5.00
6.00 Television and radio service (chapter 21)	A	-30,096	PLANT OPERATION, MAINT. & REPAIRS		5.00 6.00
7.00 Parking lot (chapter 21)	B	-11,508	CAP REL COSTS - BLDGS & FIXTURES		1.00 7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0			
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	-303,844			
13.00 Laundry and linen service	B	-1,909	LAUNDRY & LINEN SERVICE		6.00 13.00
14.00 Revenue - Employee meals	B	-29,869	DIETARY		8.00 14.00
15.00 Cost of meals - Guests		0			0.00 15.00
16.00 Sale of medical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts		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)			OUTL IZATI ON REVI EW - SNF		82.00 22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES		1.00 23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUI PMENT		2.00 24.00
25.00 MARKETING SAL/BEN/OTHER	A	-401,375	ADMI NI STRATI VE & GENERAL		4.00 25.00
25.01 NON-ALLOWABLE EXPENSE	A	-23,409	ADMI NI STRATI VE & GENERAL		4.00 25.01
25.02 MARKETING BENEFITS	A	-46,315	EMPLOYEE BENEFITS		3.00 25.02
25.03 OTHER INCOME	B	-6,299	PLANT OPERATION, MAINT. & REPAIRS		5.00 25.03
25.04 ELECTRIC REVENUE	B	-5,599	PLANT OPERATION, MAINT. & REPAIRS		5.00 25.04
25.05 MAINTENANCE SERVICES	B	-4,862	PLANT OPERATION, MAINT. & REPAIRS		5.00 25.05
25.06 INSURANCE REVENUE	B	-16,086	PLANT OPERATION, MAINT. & REPAIRS		5.00 25.06
25.07 DONATIONS	A	-100	ADMI NI STRATI VE & GENERAL		4.00 25.07
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,918,832			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. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A-8-1  
Parts I-III  
Date/Time Prepared:  
11/23/2021 9:23 am

		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 FEE	1.00
2.00		0.00			2.00
3.00		0.00			3.00
4.00		0.00			4.00
5.00		0.00			5.00
6.00		0.00			6.00
7.00		0.00			7.00
8.00		0.00			8.00
9.00		0.00			9.00
10.00	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		1,139,417	1,443,261	-303,844	1.00
2.00		0	0	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.	1,139,417	1,443,261	-303,844	10.00

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

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet A-8-1  
Parts I-II  
Date/Time Prepared:  
11/23/2021 9:23 am

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	G	UNITED METHODIST HOMES OF NJ	100.00	1.00
2.00			0.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00		UNITED METHODIST HOMES OF NJ	100.00	SUPPORT SERVICES	1.00
2.00			0.00		2.00
3.00			0.00		3.00
4.00			0.00		4.00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
	0	1.00	2.00	3.00	3A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,971,952	1,971,952			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	2,055,265	0	0	2,055,265	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,105,971	80,336	0	253,614	3,439,921 4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,622,745	35,595	0	87,208	1,745,548 5.00
6.00 00600	LAUNDRY & LINEN SERVICE	86,747	14,906	0	16,787	118,440 6.00
7.00 00700	HOUSEKEEPING	529,888	1,040	0	120,067	650,995 7.00
8.00 00800	DIETARY	2,157,959	37,752	0	213,974	2,409,685 8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	0 9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 10.00
11.00 01100	PHARMACY	0	0	0	0	0 11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 12.00
13.00 01300	SOCIAL SERVICE	37,593	1,116	0	10,059	48,768 13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0 14.00
15.00 01500	ACTIVITIES	274,427	12,147	0	59,360	345,934 15.00
15.01 01501	CHAPLAIN	55,927	0	0	14,789	70,716 15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	2,906,129	313,753	0	660,853	3,880,735 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	2,002,555	734,276	0	512,316	3,249,147 33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	6,939	0	0	0	6,939 40.00
41.00 04100	LABORATORY	46,425	0	0	0	46,425 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	51,815	0	0	8,420	60,235 43.00
44.00 04400	PHYSICAL THERAPY	226,917	11,181	0	55,498	293,596 44.00
45.00 04500	OCCUPATIONAL THERAPY	202,152	0	0	25,746	227,898 45.00
46.00 04600	SPEECH PATHOLOGY	38,283	0	0	6,020	44,303 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,153	0	0	0	10,153 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	145,317	0	0	0	145,317 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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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	0	0	0	0	0 62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
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
89.00	SUBTOTALS (sum of lines 1-84)	17,535,159	1,242,102	0	2,044,711	16,794,755 89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	55,829	0	0	10,554	66,383 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	2,013	0	0	2,013 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	NON-REIMBURSABLE	0	727,837	0	0	727,837 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	17,590,988	1,971,952	0	2,055,265	17,590,988 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	3,439,921				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	424,318	2,169,866			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	28,791	17,427	164,658		6.00	
7.00	00700	HOUSEKEEPING	158,248	1,216	0	810,459	7.00	
8.00	00800	DIETARY	585,761	44,135	0	16,628	3,056,209	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	11,855	1,305	0	491	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	84,092	14,201	0	5,350	0	15.00
15.01	01501	CHAPLAIN	17,190	0	0	0	0	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	943,347	366,807	131,726	138,192	1,085,761	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	789,822	858,438	32,932	323,411	1,970,448	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	1,687	0	0	0	0	40.00
41.00	04100	LABORATORY	11,285	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	14,642	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	71,369	13,072	0	4,925	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	55,399	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	10,769	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	2,468	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	35,325	0	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
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
89.00		SUBTOTALS (sum of lines 1-84)	3,246,368	1,316,601	164,658	488,997	3,056,209	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	16,137	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	489	2,354	0	887	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	NON-REIMBURSABLE	176,927	850,911	0	320,575	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	3,439,921	2,169,866	164,658	810,459	3,056,209	100.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	0					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	62,419	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	62,419	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	0	62,419	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		0	0	0	0	62,419	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE		Subtotal	Post Stepdown Adjustments			
		ACTIVITIES	CHAPLAIN					
		14.00	15.00				15.01	16.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES				1.00		
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00		
3.00	00300	EMPLOYEE BENEFITS				3.00		
4.00	00400	ADMINISTRATIVE & GENERAL				4.00		
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS				5.00		
6.00	00600	LAUNDRY & LINEN SERVICE				6.00		
7.00	00700	HOUSEKEEPING				7.00		
8.00	00800	DIETARY				8.00		
9.00	00900	NURSING ADMINISTRATION				9.00		
10.00	01000	CENTRAL SERVICES & SUPPLY				10.00		
11.00	01100	PHARMACY				11.00		
12.00	01200	MEDICAL RECORDS & LIBRARY				12.00		
13.00	01300	SOCIAL SERVICE				13.00		
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0			14.00		
15.00	01500	ACTIVITIES	0	449,577		15.00		
15.01	01501	CHAPLAIN	0	0	87,906	15.01		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	0	449,577	33,869	7,092,433	0	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	54,037	7,278,235	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	0	0	8,626	0	40.00
41.00	04100	LABORATORY	0	0	0	57,710	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	74,877	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	382,962	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	283,297	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	55,072	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	12,621	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	180,642	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
<b>OTHER REIMBURSABLE COST CENTERS</b>								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
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
89.00		SUBTOTALS (sum of lines 1-84)	0	449,577	87,906	15,426,475	0	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	82,520	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	5,743	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	NON-REIMBURSABLE	0	0	0	2,076,250	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	0	449,577	87,906	17,590,988	0	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		Total	
		18.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01500	ACTIVITIES	15.00
15.01	01501	CHAPLAIN	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	SKILLED NURSING FACILITY	30.00
31.00	03100	NURSING FACILITY	31.00
32.00	03200	ICF/IID	32.00
33.00	03300	OTHER LONG TERM CARE	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
40.00	04000	RADIOLOGY	40.00
41.00	04100	LABORATORY	41.00
42.00	04200	INTRAVENOUS THERAPY	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	43.00
44.00	04400	PHYSICAL THERAPY	44.00
45.00	04500	OCCUPATIONAL THERAPY	45.00
46.00	04600	SPEECH PATHOLOGY	46.00
47.00	04700	ELECTROCARDIOLOGY	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	50.00
51.00	05100	SUPPORT SURFACES	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
60.00	06000	CLINIC	60.00
61.00	06100	RURAL HEALTH CLINIC	61.00
62.00	06200	FOHC	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
70.00	07000	HOME HEALTH AGENCY COST	70.00
71.00	07100	AMBULANCE	71.00
73.00	07300	CMHC	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
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	83.00
89.00		SUBTOTALS (sum of lines 1-84)	89.00
<b>NONREIMBURSABLE COST CENTERS</b>			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	90.00
91.00	09100	BARBER AND BEAUTY SHOP	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	92.00
93.00	09300	NONPAID WORKERS	93.00
94.00	09400	PATIENTS LAUNDRY	94.00
95.00	09500	NON-REIMBURSABLE	95.00
98.00		Cross Foot Adjustments	98.00
99.00		Negative Cost Centers	99.00
100.00		TOTAL	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDGS & FIXTURES	MOVABLE EQUIPMENT		
		0	2.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	80,336	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	35,595	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	14,906	0	6.00
7.00 00700	HOUSEKEEPING	0	1,040	0	7.00
8.00 00800	DIETARY	0	37,752	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	1,116	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	14.00
15.00 01500	ACTIVITIES	0	12,147	0	15.00
15.01 01501	CHAPLAIN	0	0	0	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	SKILLED NURSING FACILITY	0	313,753	0	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	734,276	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
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	11,181	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
60.00 06000	CLINIC	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	61.00
62.00 06200	FOHC				62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	71.00
73.00 07300	CMHC	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
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
89.00	SUBTOTALS (sum of lines 1-84)	0	1,242,102	0	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	2,013	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	NON-REIMBURSABLE	0	727,837	0	95.00
98.00	Cross Foot Adjustments			0	98.00
99.00	Negative Cost Centers			0	99.00
100.00	TOTAL	0	1,971,952	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2021 9: 23 am

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400	80,336					4.00
5.00	00500	9,909	45,504				5.00
6.00	00600	672	365	15,943			6.00
7.00	00700	3,696	26	0	4,762		7.00
8.00	00800	13,680	926	0	98	52,456	8.00
9.00	00900	0	0	0	0	0	9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	277	27	0	3	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	1,964	298	0	31	0	15.00
15.01	01501	401	0	0	0	0	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	22,031	7,692	12,754	812	18,636	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	18,445	18,003	3,189	1,900	33,820	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	39	0	0	0	0	40.00
41.00	04100	264	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	342	0	0	0	0	43.00
44.00	04400	1,667	274	0	29	0	44.00
45.00	04500	1,294	0	0	0	0	45.00
46.00	04600	252	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	58	0	0	0	0	48.00
49.00	04900	825	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		75,816	27,611	15,943	2,873	52,456	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	377	0	0	0	0	90.00
91.00	09100	11	49	0	5	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	4,132	17,844	0	1,884	0	95.00
98.00				0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		80,336	45,504	15,943	4,762	52,456	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	0					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	1,423	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	1,423	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	0	1,423	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		0	0	0	0	1,423	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE		Subtotal	Post Step-Down Adjustments	
		ACTIVITIES	CHAPLAIN			
		14.00	15.01			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	14,440			15.00
15.01 01501	CHAPLAIN	0	0	401		15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	0	14,440	155	391,696	0 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	246	809,879	0 33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	39	0 40.00
41.00 04100	LABORATORY	0	0	0	264	0 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	342	0 43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	13,151	0 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	1,294	0 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	252	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	58	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	825	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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
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
89.00	SUBTOTALS (sum of lines 1-84)	0	14,440	401	1,217,800	0 89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	377	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	2,078	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	NON-REIMBURSABLE	0	0	0	751,697	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	0	14,440	401	1,971,952	0 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		Total	
		18.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100		1.00
2.00	00200		2.00
3.00	00300		3.00
4.00	00400		4.00
5.00	00500		5.00
6.00	00600		6.00
7.00	00700		7.00
8.00	00800		8.00
9.00	00900		9.00
10.00	01000		10.00
11.00	01100		11.00
12.00	01200		12.00
13.00	01300		13.00
14.00	01400		14.00
15.00	01500		15.00
15.01	01501		15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	391,696	30.00
31.00	03100	0	31.00
32.00	03200	0	32.00
33.00	03300	809,879	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
40.00	04000	39	40.00
41.00	04100	264	41.00
42.00	04200	0	42.00
43.00	04300	342	43.00
44.00	04400	13,151	44.00
45.00	04500	1,294	45.00
46.00	04600	252	46.00
47.00	04700	0	47.00
48.00	04800	58	48.00
49.00	04900	825	49.00
50.00	05000	0	50.00
51.00	05100	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
60.00	06000	0	60.00
61.00	06100	0	61.00
62.00	06200	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
70.00	07000	0	70.00
71.00	07100	0	71.00
73.00	07300	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
80.00	08000		80.00
81.00	08100		81.00
82.00	08200		82.00
83.00	08300	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)		1,217,800
<b>NONREIMBURSABLE COST CENTERS</b>			
90.00	09000	377	90.00
91.00	09100	2,078	91.00
92.00	09200	0	92.00
93.00	09300	0	93.00
94.00	09400	0	94.00
95.00	09500	751,697	95.00
98.00	Cross Foot Adjustments		0
99.00	Negative Cost Centers		0
100.00	TOTAL		1,971,952



COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B-1

Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	261,540					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	7,680,916			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	10,655	0	947,801	-3,439,921	14,151,067	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	4,721	0	325,914	0	1,745,548	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,977	0	62,738	0	118,440	6.00
7.00 00700	HOUSEKEEPING	138	0	448,713	0	650,995	7.00
8.00 00800	DIETARY	5,007	0	799,659	0	2,409,685	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	148	0	37,593	0	48,768	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	1,611	0	221,839	0	345,934	15.00
15.01 01501	CHAPLAIN	0	0	55,268	0	70,716	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	SKILLED NURSING FACILITY	41,613	0	2,469,745	0	3,880,735	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	97,387	0	1,914,619	0	3,249,147	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00 04000	RADIOLOGY	0	0	0	0	6,939	40.00
41.00 04100	LABORATORY	0	0	0	0	46,425	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	31,466	0	60,235	43.00
44.00 04400	PHYSICAL THERAPY	1,483	0	207,407	0	293,596	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	96,216	0	227,898	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	22,497	0	44,303	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,153	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	145,317	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
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
89.00	SUBTOTALS (sum of lines 1-84)	164,740	0	7,641,475	-3,439,921	13,354,834	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	39,441	0	66,383	90.00
91.00 09100	BARBER AND BEAUTY SHOP	267	0	0	0	2,013	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	NON-REIMBURSABLE	96,533	0	0	0	727,837	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)	1,971,952	0	2,055,265		3,439,921	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	7.539772	0.000000	0.267581		0.243086	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		80,336	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.005677	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B-1

Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION  (DIRECT NURSING)	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	246,164					6.00
7.00	00700	1,977	244,420				7.00
8.00	00800	138	0	244,049			8.00
9.00	00900	5,007	0	5,007	134,849		9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	148	0	148	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	1,611	0	1,611	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	41,613	195,536	41,613	47,907	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	97,387	48,884	97,387	86,942	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,483	0	1,483	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		149,364	244,420	147,249	134,849	0	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	267	0	267	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	96,533	0	96,533	0	0	95.00
98.00							98.00
99.00							99.00
102.00		2,169,866	164,658	810,459	3,056,209	0	102.00
103.00		8.814717	0.673668	3.320886	22.663935	0.000000	103.00
104.00		45,504	15,943	4,762	52,456	0	104.00
105.00		0.184852	0.065228	0.019512	0.388998	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B-1  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	0					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	15,969		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	15,969	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0		0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	15,969	0	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00		0	0	0	62,419	0	102.00
103.00		0.000000	0.000000	0.000000	3.908761	0.000000	103.00
104.00		0	0	0	1,423	0	104.00
105.00		0.000000	0.000000	0.000000	0.089110	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet B-1  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		OTHER GENERAL SERVICE			
		ACTIVITIES (PATIENT DAYS)	CHAPLAIN (PATIENT DAYS)		
		15.00	15.01		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3.00	00300	EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5.00
6.00	00600	LAUNDRY & LINEN SERVICE			6.00
7.00	00700	HOUSEKEEPING			7.00
8.00	00800	DIETARY			8.00
9.00	00900	NURSING ADMINISTRATION			9.00
10.00	01000	CENTRAL SERVICES & SUPPLY			10.00
11.00	01100	PHARMACY			11.00
12.00	01200	MEDICAL RECORDS & LIBRARY			12.00
13.00	01300	SOCIAL SERVICE			13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION			14.00
15.00	01500	ACTIVITIES	15,969		15.00
15.01	01501	CHAPLAIN	0	41,447	15.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	15,969	15,969	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	25,478	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	0	0	40.00
41.00	04100	LABORATORY	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC			62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
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
89.00		SUBTOTALS (sum of lines 1-84)	15,969	41,447	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	NON-REIMBURSABLE	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)	449,577	87,906	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	28.153109	2.120926	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	14,440	401	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.904252	0.009675	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet C Date/Time Prepared: 11/23/2021 9:23 am	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	8,626	6,580	1.310942 40.00
41.00	04100	LABORATORY	57,710	46,425	1.243080 41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	74,877	51,815	1.445083 43.00
44.00	04400	PHYSICAL THERAPY	382,962	401,993	0.952658 44.00
45.00	04500	OCCUPATIONAL THERAPY	283,297	323,534	0.875633 45.00
46.00	04600	SPEECH PATHOLOGY	55,072	48,208	1.142383 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000 47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,621	10,153	1.243081 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	180,642	144,630	1.248994 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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
60.00	06000	CLINIC	0	0	0.000000 60.00
61.00	06100	RURAL HEALTH CLINIC			61.00
62.00	06200	FQHC			62.00
71.00	07100	AMBULANCE	0	0	0.000000 71.00
100.00		Total	1,055,807	1,033,338	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Prepared: 11/23/2021 9:23 am			
		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)		
		2.00	3.00	4.00	5.00		
<b>PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST</b>							
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000 RADIOLOGY	1.310942	5,660	0	7,420	0	40.00
41.00	04100 LABORATORY	1.243080	34,023	0	42,293	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1.445083	0	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	0.952658	190,589	0	181,566	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0.875633	185,996	0	162,864	0	45.00
46.00	04600 SPEECH PATHOLOGY	1.142383	20,381	0	23,283	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.243081	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.248994	126,495	0	157,991	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
71.00	07100 AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		563,144	0	575,417	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. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet D Parts II-III Date/Time Prepared: 11/23/2021 9:23 am
		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)					1.248994	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	8,626	0	0.000000	7,420	0 40.00	
41.00	04100	LABORATORY	57,710	0	0.000000	42,293	0 41.00	
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0 42.00	
43.00	04300	OXYGEN (INHALATION) THERAPY	74,877	0	0.000000	0	0 43.00	
44.00	04400	PHYSICAL THERAPY	382,962	0	0.000000	181,566	0 44.00	
45.00	04500	OCCUPATIONAL THERAPY	283,297	0	0.000000	162,864	0 45.00	
46.00	04600	SPEECH PATHOLOGY	55,072	0	0.000000	23,283	0 46.00	
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0 47.00	
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,621	0	0.000000	0	0 48.00	
49.00	04900	DRUGS CHARGED TO PATIENTS	180,642	0	0.000000	157,991	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	
100.00		Total (Sum of lines 40 - 52)	1,055,807	0		575,417	0 100.00	

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Parts I-II Date/Time Prepared: 11/23/2021 9:23 am
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
<b>PART I CALCULATION OF INPATIENT ROUTINE COSTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days including private room days		15,969	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		2,302	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		7,092,433	5.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
6.00	General inpatient routine service charges		7,824,220	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.906472	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		7,824,220	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		489.96	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)		7,092,433	15.00
<b>PROGRAM INPATIENT ROUTINE SERVICE COSTS</b>				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		444.14	16.00
17.00	Program routine service cost (Line 3 times line 16)		1,022,410	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)		1,022,410	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)		391,696	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		24.53	21.00
22.00	Program capital related cost (Line 3 times line 21)		56,468	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		965,942	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)		965,942	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	
<b>PART II CALCULATION OF INPATIENT NURSING &amp; ALLIED HEALTH COSTS FOR PPS PASS-THROUGH</b>				
1.00	Total SNF inpatient days		15,969	1.00
2.00	Program inpatient days (see instructions)		2,302	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)		0.144154	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. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Parts I-III Date/Time Prepared: 11/23/2021 9:23 am
		Title XIX	Skilled Nursing Facility	Cost

				1.00	
<b>PART I CALCULATION OF INPATIENT ROUTINE COSTS</b>					
<b>INPATIENT DAYS</b>					
1.00	Inpatient days including private room days		15,969	1.00	
2.00	Private room days		0	2.00	
3.00	Inpatient days including private room days applicable to the Program		4,769	3.00	
4.00	Medically necessary private room days applicable to the Program		0	4.00	
5.00	Total general inpatient routine service cost		7,092,433	5.00	
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>					
6.00	General inpatient routine service charges		7,824,220	6.00	
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.906472	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		7,824,220	10.00	
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		489.96	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)		7,092,433	15.00	
<b>PROGRAM INPATIENT ROUTINE SERVICE COSTS</b>					
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		444.14	16.00	
17.00	Program routine service cost (Line 3 times line 16)		2,118,104	17.00	
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00	
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		2,118,104	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)		391,696	20.00	
21.00	Per diem capital related costs (Line 20 divided by line 1)		24.53	21.00	
22.00	Program capital related cost (Line 3 times line 21)		116,984	22.00	
23.00	Inpatient routine service cost (Line 19 minus line 22)		2,001,120	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)		2,001,120	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)		2,118,104	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	
<b>PART II CALCULATION OF INPATIENT NURSING &amp; ALLIED HEALTH COSTS FOR PPS PASS-THROUGH</b>					
1.00	Total SNF inpatient days		15,969	1.00	
2.00	Program inpatient days (see instructions)		4,769	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)		0.298641	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 XVIIII		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part I Date/Time Prepared: 11/23/2021 9:23 am
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
--	--	--	------	--

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		1,458,474	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)		1,458,474	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		91,207	5.00
6.00	Allowable bad debts (From your records)		2,558	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		1,663	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)		1,368,930	11.00
12.00	Interim payments (See instructions)		1,367,267	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)		1,663	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 XVIIII 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

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part II Date/Time Prepared: 11/23/2021 9:23 am
		Title XIX	Skilled Nursing Facility	Cost
				1.00
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		2,118,104	4.00
5.00	Utilization review--physicians' compensation (from provider records)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)		2,118,104	6.00
7.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		2,118,104	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		2,118,104	10.00
<b>REASONABLE CHARGES</b>				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
<b>CUSTOMARY CHARGES</b>				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet E-1

Date/Time Prepared:  
11/23/2021 9:23 am

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					1.00	
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		1,367,267		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)		1,367,267		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		1,663		0	6.01	
6.02	PROVIDER TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,368,930		0	7.00	
			Contractor Name		Contractor Number		
			1.00		2.00		
8.00	Name of Contractor	Novitas Solutions			12001		8.00

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

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

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet G  
Date/Time Prepared:  
11/23/2021 9:23 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>Assets</b>						
<b>CURRENT ASSETS</b>						
1.00	Cash on hand and in banks	1,460,103	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,799,451	0	0	0	4.00
5.00	Other receivables	193	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-511,453	0	0	0	6.00
7.00	Inventory	193,772	0	0	0	7.00
8.00	Prepaid expenses	173,341	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	<b>TOTAL CURRENT ASSETS (Sum of lines 1 - 10)</b>	<b>3,115,407</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	2,319,707	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	58,523,265	0	0	0	15.00
16.00	Less Accumulated depreciation	-23,969,443	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	117,127	0	0	0	21.00
22.00	Less: Accumulated depreciation	-117,127	0	0	0	22.00
23.00	Major movable equipment	3,775,035	0	0	0	23.00
24.00	Less: Accumulated depreciation	-2,341,676	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	1,805,638	0	0	0	27.00
28.00	<b>TOTAL FIXED ASSETS (Sum of lines 12 - 27)</b>	<b>40,112,526</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28.00</b>
<b>OTHER ASSETS</b>						
29.00	Investments	26,614,247	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	8,097,830	0	0	0	32.00
33.00	<b>TOTAL OTHER ASSETS (Sum of lines 29 - 32)</b>	<b>34,712,077</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33.00</b>
34.00	<b>TOTAL ASSETS (Sum of lines 11, 28, and 33)</b>	<b>77,940,010</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34.00</b>
<b>Liabilities and Fund Balances</b>						
<b>CURRENT LIABILITIES</b>						
35.00	Accounts payable	1,002,460	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,391,416	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	1,782,560	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	<b>TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)</b>	<b>4,176,436</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43.00</b>
<b>LONG TERM LIABILITIES</b>						
44.00	Mortgage payable	22,886,813	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	17,538,926	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	<b>TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)</b>	<b>40,425,739</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>TOTAL LIABILITIES (Sum of lines 43 and 50)</b>	<b>44,602,175</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	33,337,835	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	<b>TOTAL FUND BALANCES (Sum of lines 52 thru 58)</b>	<b>33,337,835</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>59.00</b>
60.00	<b>TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)</b>	<b>77,940,010</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet G-1

Date/Time Prepared:  
11/23/2021 9:23 am

		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		29,195,394			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		4,142,440				2.00
3.00	Total (sum of line 1 and line 2)		33,337,834			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDING	1		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		1			0	10.00
11.00	Subtotal (line 3 plus line 10)		33,337,835			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)		33,337,835			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	ROUNDING		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. : 315439

Period:  
From 07/01/2020  
To 06/30/2021

Worksheet G-2  
Parts I-III  
Date/Time Prepared:  
11/23/2021 9:23 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Care Services</b>					
1.00	SKILLED NURSING FACILITY	7,824,220		7,824,220	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	7,703,608		7,703,608	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	15,527,828		15,527,828	5.00
<b>All Other Care Services</b>					
6.00	ANCILLARY SERVICES	973,424	0	973,424	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	INDEPENDENT LIVING REVENUES	4,980,880	0	4,980,880	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	21,482,132	0	21,482,132	14.00
			1.00	2.00	
<b>PART II - OPERATING EXPENSES</b>					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			19,509,820	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)			19,509,820	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider No. : 315439	Period: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/23/2021 9:23 am
				1.00
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			21,482,132 1.00
2.00	Less: contractual allowances and discounts on patients accounts			2,849,719 2.00
3.00	Net patient revenues (Line 1 minus line 2)			18,632,413 3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)			19,509,820 4.00
5.00	Net income from service to patients (Line 3 minus 4)			-877,407 5.00
	<b>Other income:</b>			
6.00	Contributions, donations, bequests, etc			94,107 6.00
7.00	Income from investments			4,283,664 7.00
8.00	Revenues from communications ( Telephone and Internet service)			0 8.00
9.00	Revenue from television and radio service			47,616 9.00
10.00	Purchase discounts			0 10.00
11.00	Rebates and refunds of expenses			0 11.00
12.00	Parking lot receipts			11,508 12.00
13.00	Revenue from laundry and linen service			1,909 13.00
14.00	Revenue from meals sold to employees and guests			29,869 14.00
15.00	Revenue from rental of living quarters			13,000 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	GAIN ON SALE OF ASSETS			1,637 24.00
24.01	CATERING/COUNTRY STORE			11,717 24.01
24.02	UTILITY INCOME			5,599 24.02
24.03	TRANS - RESIDENTIAL			25,440 24.03
24.04	MISCELLANEOUS INCOME			117,877 24.04
24.05	HOUSEKEEPING REVENUE			0 24.05
24.06	MAINTENANCE REVENUE			4,862 24.06
24.07	IT SUPPORT REVENUE			1,715 24.07
24.08	GRANT REVENUE			288,316 24.08
24.09	INSURANCE REVENUE			16,086 24.09
24.50	COVID-19 PHE Funding			65,064 24.50
25.00	Total other income (Sum of lines 6 - 24)			5,019,986 25.00
26.00	Total (Line 5 plus line 25)			4,142,579 26.00
27.00	HOUSEKEEPING REVENUE			139 27.00
28.00				0 28.00
29.00				0 29.00
30.00	Total other expenses (Sum of lines 27 - 29)			139 30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)			4,142,440 31.00