

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: 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I, II & III Date/Time Prepared: 11/15/2021 2:32 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date:	Time:
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Contractor No. _____	7. <input type="checkbox"/> First Cost Report for this Provider CCN
	5. Date Received: _____	8. <input type="checkbox"/> Last Cost Report for this Provider CCN	9. NPR Date: _____
		10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened	11. Contractor Vendor Code <u>4</u>
		12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PITMAN MANOR (315427) 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	1	2	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	5,191	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	5,191	0	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/15/2021 2:32 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 535 NORTH OAK AVENUE	PO Box:				1.00		
2.00	City: PITMAN	State: NJ	Zip Code: 08071			2.00		
3.00	County: GLOUCESTER	CBSA Code: 15804	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	PITMAN MANOR	315427	11/30/1993	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					549,359		
21.00	Declining Balance					0		
22.00	Sum of the Year's Digits					0		
23.00	Sum of line 20 through 22					549,359		
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	N	N
30.00	Skilled Nursing Facility							
31.00	Nursing Facility							
32.00	ICF/IID							
33.00	SNF-Based HHA					N	N	
34.00	SNF-Based RHC							
35.00	SNF-Based FOHC						N	
36.00	SNF-Based CMHC							
36.00	SNF-Based OLTC							
				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:			89,556	0	0	41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/15/2021 2:32 pm
				Y/N
				1.00
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N 42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			Y 43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			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 45.00	
46.00	Street: 3311 HIGHWAY 33	PO Box:	46.00	
47.00	City: NEPTUNE	State: NJ	Zip Code: 07753	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/15/2021 2:32 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	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. : 315427

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 11/15/2021 2:32 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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. : 315427

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 11/15/2021 2:32 pm

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

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

Provider No. : 315427

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 11/15/2021 2:32 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	72	26,280	0	2,339	10,761	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	178	64,970				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)	250	91,250	0	2,339	10,761	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	8,067	21,167	0	62	16	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	42,486	42,486				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)	50,553	63,653	0	62	16	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	39	117	0.00	37.73	672.56	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	58	58				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)	97	175	0.00	37.73	672.56	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	180.91	0	86	7	28	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	732.52				45	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)	363.73	0	86	7	73	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	121	41.99	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				4.00		
5.00	Other Long Term Care	45	38.68	0.00	5.00		
6.00	SNF-Based CMHC				6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of Lines 1-7)	166	80.67	0.00	8.00		

Provider No. : 315427

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

Worksheet S-3
Part II
Date/Time Prepared:
11/15/2021 2:32 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	7,892,268	0	7,892,268	329,837.00	23.93 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)	7,892,268	0	7,892,268	329,837.00	23.93 6.00
7.00	Other Long Term Care	1,864,533	0	1,864,533	80,458.00	23.17 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	26,111	0	26,111	3,398.00	7.68 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	1,890,644	0	1,890,644	83,856.00	22.55 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	6,001,624	0	6,001,624	245,981.00	24.40 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	279,779	0	279,779	6,746.00	41.47 14.00
15.00	Contract Labor: Physician services-Part A	21,006	0	21,006	104.00	201.98 15.00
16.00	Home office salaries & wage related costs	695,578	0	695,578	11,968.00	58.12 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1,745,859	0	1,745,859		
18.00	Wage-related costs other (See Part IV)	3,780	0	3,780		
19.00	Wage related costs (excluded units)	419,137	0	419,137		
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)	1,330,502	0	1,330,502		

Provider No. : 315427

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

Worksheet S-3
Part III
Date/Time Prepared:
11/15/2021 2:32 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	1,119,983	0	1,119,983	30,031.00	2.00
3.00	Plant Operation, Maintenance & Repairs	373,447	0	373,447	24,006.00	3.00
4.00	Laundry & Linen Service	75,557	0	75,557	5,072.00	4.00
5.00	Housekeeping	469,835	0	469,835	27,656.00	5.00
6.00	Dietary	766,261	0	766,261	48,384.00	6.00
7.00	Nursing Administration	0	0	0	0.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	60,682	0	60,682	2,056.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	259,014	0	259,014	13,105.00	13.00
14.00	Total (sum lines 1 thru 13)	3,124,779	0	3,124,779	150,310.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/15/2021 2:32 pm
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			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		119,778	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		657,432	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		10,263	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)		3,134	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		282,249	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		577,564	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		93,939	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		1,500	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		1,745,859	24.00
			Amount Reported	
			1.00	
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		3,780	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315427

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

Worksheet S-3
Part V
Date/Time Prepared:
11/15/2021 2:32 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	1,281,651	284,142	1,565,793	27,734.00	56.46	1.00
2.00	Licensed Practical Nurses (LPNs)	134,998	29,929	164,927	3,889.00	42.41	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	938,977	208,171	1,147,148	48,468.00	23.67	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,355,626	522,242	2,877,868	80,091.00	35.93	4.00
5.00	Physical Therapists	171,304	37,978	209,282	3,993.00	52.41	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	33,107	7,340	40,447	606.00	66.74	8.00
9.00	Occupational Therapy Assistants	51,843	11,494	63,337	1,619.00	39.12	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	37,830	8,387	46,217	733.00	63.05	11.00
12.00	Respiratory Therapists	51,646	11,450	63,096	1,382.00	45.66	12.00
13.00	Other Medical Staff	175,490	38,906	214,396	7,248.00	29.58	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	113,713		113,713	2,031.00	55.99	14.00
15.00	Licensed Practical Nurses (LPNs)	99,983		99,983	2,173.00	46.01	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	66,083		66,083	2,542.00	26.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	279,779		279,779	6,746.00	41.47	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. : 315427

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

Worksheet S-7

Date/Time Prepared:
11/15/2021 2:32 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315427

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

Worksheet S-7

Date/Time Prepared:
11/15/2021 2:32 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315427

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

Worksheet A
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		611,115	611,115	0	611,115	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300	0	1,749,639	1,749,639	0	1,749,639	3.00
4.00	00400	1,119,983	2,455,145	3,575,128	0	3,575,128	4.00
5.00	00500	373,447	785,026	1,158,473	0	1,158,473	5.00
6.00	00600	75,557	18,086	93,643	0	93,643	6.00
7.00	00700	469,835	133,647	603,482	0	603,482	7.00
8.00	00800	766,261	1,131,004	1,897,265	0	1,897,265	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	60,682	0	60,682	0	60,682	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	191,601	38,091	229,692	0	229,692	15.00
15.01	01501	67,413	380	67,793	0	67,793	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,531,116	626,386	3,157,502	0	3,157,502	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	1,864,533	99,590	1,964,123	0	1,964,123	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	5,319	5,319	0	5,319	40.00
41.00	04100	0	11,699	11,699	0	11,699	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	51,646	3,705	55,351	0	55,351	43.00
44.00	04400	171,303	94,522	265,825	-99,786	166,039	44.00
45.00	04500	84,950	0	84,950	74,052	159,002	45.00
46.00	04600	37,830	0	37,830	25,734	63,564	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	10,220	10,220	0	10,220	48.00
49.00	04900	0	123,144	123,144	0	123,144	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
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		7,866,157	7,896,718	15,762,875	0	15,762,875	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	26,111	5,026	31,137	0	31,137	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
100.00		7,892,268	7,901,744	15,794,012	0	15,794,012	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315427

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

Worksheet A
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-354	610,761	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	-40,381	1,709,258	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-840,286	2,734,842	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	-17,078	1,141,395	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	-108	93,535	6.00
7.00	00700	HOUSEKEEPING	-621	602,861	7.00
8.00	00800	DIETARY	0	1,897,265	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	60,682	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	229,692	15.00
15.01	01501	CHAPLAIN	0	67,793	15.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	3,157,502	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	1,964,123	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	5,319	40.00
41.00	04100	LABORATORY	0	11,699	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	55,351	43.00
44.00	04400	PHYSICAL THERAPY	0	166,039	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	159,002	45.00
46.00	04600	SPEECH PATHOLOGY	0	63,564	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,220	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	123,144	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FQHC	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
SPECIAL PURPOSE COST CENTERS					
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)	-898,828	14,864,047	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	31,137	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
100.00		TOTAL	-898,828	14,895,184	100.00

RECLASSIFICATIONS

Provider No. : 315427

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

Worksheet A-6

Date/Time Prepared:
11/15/2021 2:32 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
	(1) A - TO RECLASS OT AND ST					
1.00		OCCUPATIONAL THERAPY	45.00	34,258	39,794	1.00
2.00		SPEECH PATHOLOGY	46.00	11,905	13,829	2.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		46,163	53,623	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. : 315427

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

Worksheet A-6

Date/Time Prepared:
11/15/2021 2:32 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	(1) A - TO RECLASS OT AND ST					
1.00		PHYSICAL THERAPY	44.00	46,163	53,623	1.00
2.00			0.00	0	0	2.00
	TOTALS			46,163	53,623	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. : 315427

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

Worksheet A-7

Date/Time Prepared:
11/15/2021 2:32 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	39,437	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	14,145,977	136,291	0	136,291	1,079	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	1,595,768	373,860	0	373,860	0	5.00
6.00 Movable Equipment	171,892	0	0	0	0	6.00
7.00 Subtotal (sum of lines 1-6)	15,953,074	510,151	0	510,151	1,079	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	15,953,074	510,151	0	510,151	1,079	9.00
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	39,437	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	14,281,189	0				
4.00 Building Improvements	0	0				
5.00 Fixed Equipment	1,969,628	0				
6.00 Movable Equipment	171,892	0				
7.00 Subtotal (sum of lines 1-6)	16,462,146	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	16,462,146	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315427

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

Worksheet A-8

Date/Time Prepared:
11/15/2021 2:32 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line No.	
			1.00	2.00	3.00
1.00 Investment income on restricted funds (chapter 2)		0			0.00 1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 2.00
3.00 Refunds and rebates of expenses (chapter 8)		0			0.00 3.00
4.00 Rental of provider space by suppliers (chapter 8)		0			0.00 4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 5.00
6.00 Television and radio service (chapter 21)	B	-16,628	PLANT OPERATION, MAINT. & REPAIRS		5.00 6.00
7.00 Parking lot (chapter 21)	B	-354	CAP REL COSTS - BLDGS & FIXTURES		1.00 7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00 Home office cost (chapter 21)		0			0.00 9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00 11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-151,352			12.00
13.00 Laundry and linen service	B	-108	LAUNDRY & LINEN SERVICE		6.00 13.00
14.00 Revenue - Employee meals		0			0.00 14.00
15.00 Cost of meals - Guests		0			0.00 15.00
16.00 Sale of medical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts		0			0.00 18.00
19.00 Vending machines		0			0.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - 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 EQUIPMENT		2.00 24.00
25.00 MARKETING SAL/OTHER	A	-403,411	ADMINISTRATIVE & GENERAL		4.00 25.00
25.01 MARKETING BENEFITS	A	-40,381	EMPLOYEE BENEFITS		3.00 25.01
25.02 NON-ALLOWABLE EXPENSES	A	-13,527	ADMINISTRATIVE & GENERAL		4.00 25.02
25.03 BED TAX ASSESSMENT	A	-271,996	ADMINISTRATIVE & GENERAL		4.00 25.03
25.04 ELECTRIC REVENUE	B	-450	PLANT OPERATION, MAINT. & REPAIRS		5.00 25.04
25.05 HOUSEKEEPING SERVICES	B	-621	HOUSEKEEPING		7.00 25.05
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-898,828			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. : 315427

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

Worksheet A-8-1
Parts 1-11
Date/Time Prepared:
11/15/2021 2:32 pm

	Line No.	Cost Center		Expense Items		
	1.00	2.00		3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	ADMINISTRATIVE & GENERAL		HOME OFFICE ALLOCATION	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	922,404	1,073,756	-151,352		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.				10.00	
		922,404	1,073,756	-151,352		

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Parts I-III Date/Time Prepared: 11/15/2021 2:32 pm
	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

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

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

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

1.00		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. : 315427

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

Worksheet B
Part I
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	610,761	610,761			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	1,709,258	0	0	1,709,258	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,734,842	26,089	0	2,760,931	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,141,395	6,805	0	1,148,200	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	93,535	8,318	0	101,853	6.00
7.00 00700	HOUSEKEEPING	602,861	3,781	0	606,642	7.00
8.00 00800	DIETARY	1,897,265	15,879	0	1,913,144	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	60,682	1,892	0	62,574	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	229,692	9,074	0	238,766	15.00
15.01 01501	CHAPLAIN	67,793	0	0	67,793	15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	3,157,502	97,833	0	3,255,335	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	1,964,123	438,546	0	2,402,669	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	5,319	0	0	5,319	40.00
41.00 04100	LABORATORY	11,699	0	0	11,699	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	55,351	0	0	55,351	43.00
44.00 04400	PHYSICAL THERAPY	166,039	1,788	0	167,827	44.00
45.00 04500	OCCUPATIONAL THERAPY	159,002	0	0	159,002	45.00
46.00 04600	SPEECH PATHOLOGY	63,564	0	0	63,564	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,220	0	0	10,220	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	123,144	0	0	123,144	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
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	83.00
89.00	SUBTOTALS (sum of lines 1-84)	14,864,047	610,005	0	15,474,052	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	31,137	0	0	31,137	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	756	0	756	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	14,895,184	610,761	0	15,505,945	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315427

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

Worksheet B
Part I
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	2,968,841				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	306,431	1,537,420			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	29,524	22,129	170,256		6.00	
7.00	00700	HOUSEKEEPING	176,940	10,059	0	897,799	7.00	
8.00	00800	DIETARY	518,527	42,246	0	25,198	2,668,987	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	21,307	5,034	0	3,003	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	70,010	24,141	0	14,399	0	15.00
15.01	01501	CHAPLAIN	20,596	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	950,040	260,287	127,692	155,248	1,075,375	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	698,612	1,166,755	42,564	695,914	1,593,612	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	1,324	0	0	0	0	40.00
41.00	04100	LABORATORY	2,912	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	16,629	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	51,231	4,757	0	2,837	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	44,269	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	17,911	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	2,544	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	30,654	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
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS								
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)	2,959,461	1,535,408	170,256	896,599	2,668,987	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	9,192	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	188	2,012	0	1,200	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
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	2,968,841	1,537,420	170,256	897,799	2,668,987	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315427

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

Worksheet B
Part I
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	0					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	114,939	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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	114,939	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	0	114,939	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		0	0	0	0	114,939	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315427

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

Worksheet B
Part I
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE		Subtotal	Post Stepdown Adjustments	
		ACTIVITIES	CHAPLAIN			
		14.00	15.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	389,792			15.00
15.01 01501	CHAPLAIN	0	0	103,334		15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	389,792	34,362	6,924,193	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	68,972	7,072,878	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	6,643	0 40.00
41.00 04100	LABORATORY	0	0	0	14,611	0 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	83,429	0 43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	264,628	0 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	222,104	0 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	89,862	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	12,764	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	153,798	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
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
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	389,792	103,334	14,844,910	0 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	46,118	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	4,156	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
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	389,792	103,334	14,895,184	0 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315427

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

Worksheet B
Part I
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01500	ACTIVITIES	15.00
15.01	01501	CHAPLAIN	15.01
INPATIENT ROUTINE SERVICE COST CENTERS			
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
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	40.00
41.00	04100	LABORATORY	41.00
42.00	04200	INTRAVENOUS THERAPY	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	43.00
44.00	04400	PHYSICAL THERAPY	44.00
45.00	04500	OCCUPATIONAL THERAPY	45.00
46.00	04600	SPEECH PATHOLOGY	46.00
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
OUTPATIENT SERVICE COST CENTERS			
60.00	06000	CLINIC	60.00
61.00	06100	RURAL HEALTH CLINIC	61.00
62.00	06200	FOHC	62.00
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	70.00
71.00	07100	AMBULANCE	71.00
73.00	07300	CMHC	73.00
SPECIAL PURPOSE COST CENTERS			
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
NONREIMBURSABLE COST CENTERS			
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
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. : 315427

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

Worksheet B
Part II
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00	00300	EMPLOYEE BENEFITS	0	0	0	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	26,089	0	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	6,805	0	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	8,318	0	6.00
7.00	00700	HOUSEKEEPING	0	3,781	0	7.00
8.00	00800	DIETARY	0	15,879	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	1,892	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	14.00
15.00	01500	ACTIVITIES	0	9,074	0	15.00
15.01	01501	CHAPLAIN	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	0	97,833	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	438,546	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	1,788	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
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	61.00
62.00	06200	FQHC				62.00
OTHER REIMBURSABLE COST CENTERS						
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	71.00
73.00	07300	CMHC	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00	08100	INTEREST EXPENSE				81.00
82.00	08200	UTILIZATION REVIEW - SNF				82.00
83.00	08300	HOSPICE	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	0	610,005	0	89.00
NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	756	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
98.00		Cross Foot Adjustments				98.00
99.00		Negative Cost Centers				99.00
100.00		TOTAL	0	610,761	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der No. : 315427		Period: From 07/01/2020 To 06/30/2021		Worksheet B Part II Date/Time Prepared: 11/15/2021 2: 32 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400	26,089					4.00
5.00	00500	2,693	9,498				5.00
6.00	00600	260	137	8,715			6.00
7.00	00700	1,555	62	0	5,398		7.00
8.00	00800	4,558	261	0	152	20,850	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	187	31	0	18	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	615	149	0	87	0	15.00
15.01	01501	181	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,345	1,608	6,536	933	8,401	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	6,141	7,209	2,179	4,184	12,449	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	12	0	0	0	0	40.00
41.00	04100	26	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	146	0	0	0	0	43.00
44.00	04400	450	29	0	17	0	44.00
45.00	04500	389	0	0	0	0	45.00
46.00	04600	157	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	22	0	0	0	0	48.00
49.00	04900	269	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
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		26,006	9,486	8,715	5,391	20,850	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	81	0	0	0	0	90.00
91.00	09100	2	12	0	7	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
98.00				0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		26,089	9,498	8,715	5,398	20,850	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315427

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

Worksheet B
Part II
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	0					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	2,128	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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	2,128	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	0	2,128	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		0	0	0	0	2,128	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315427

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

Worksheet B
Part II
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE		Subtotal	Post Step-Down Adjustments
		ACTIVITIES	CHAPLAIN		
		14.00	15.01		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00 00300	EMPLOYEE BENEFITS				3.00
4.00 00400	ADMINISTRATIVE & GENERAL				4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 00600	LAUNDRY & LINEN SERVICE				6.00
7.00 00700	HOUSEKEEPING				7.00
8.00 00800	DIETARY				8.00
9.00 00900	NURSING ADMINISTRATION				9.00
10.00 01000	CENTRAL SERVICES & SUPPLY				10.00
11.00 01100	PHARMACY				11.00
12.00 01200	MEDICAL RECORDS & LIBRARY				12.00
13.00 01300	SOCIAL SERVICE				13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0			14.00
15.00 01500	ACTIVITIES	0	9,925		15.00
15.01 01501	CHAPLAIN	0	0	181	15.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	SKILLED NURSING FACILITY	0	9,925	60	135,769
31.00 03100	NURSING FACILITY	0	0	0	0
32.00 03200	ICF/IID	0	0	0	0
33.00 03300	OTHER LONG TERM CARE	0	0	121	470,829
ANCILLARY SERVICE COST CENTERS					
40.00 04000	RADIOLOGY	0	0	0	12
41.00 04100	LABORATORY	0	0	0	26
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	146
44.00 04400	PHYSICAL THERAPY	0	0	0	2,284
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	389
46.00 04600	SPEECH PATHOLOGY	0	0	0	157
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	22
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	269
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0
51.00 05100	SUPPORT SURFACES	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
60.00 06000	CLINIC	0	0	0	0
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0
62.00 06200	FOHC				
OTHER REIMBURSABLE COST CENTERS					
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0
71.00 07100	AMBULANCE	0	0	0	0
73.00 07300	CMHC	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00 08100	INTEREST EXPENSE				81.00
82.00 08200	UTILIZATION REVIEW - SNF				82.00
83.00 08300	HOSPICE	0	0	0	0
89.00	SUBTOTALS (sum of lines 1-84)	0	9,925	181	609,903
NONREIMBURSABLE COST CENTERS					
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	81
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	777
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0
93.00 09300	NONPAID WORKERS	0	0	0	0
94.00 09400	PATIENTS LAUNDRY	0	0	0	0
98.00	Cross Foot Adjustments	0	0	0	0
99.00	Negative Cost Centers	0	0	0	0
100.00	TOTAL	0	9,925	181	610,761

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315427

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

Worksheet B
Part II
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01500	ACTIVITIES	15.00
15.01	01501	CHAPLAIN	15.01
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	135,769
31.00	03100	NURSING FACILITY	0
32.00	03200	ICF/IID	0
33.00	03300	OTHER LONG TERM CARE	470,829
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	12
41.00	04100	LABORATORY	26
42.00	04200	INTRAVENOUS THERAPY	0
43.00	04300	OXYGEN (INHALATION) THERAPY	146
44.00	04400	PHYSICAL THERAPY	2,284
45.00	04500	OCCUPATIONAL THERAPY	389
46.00	04600	SPEECH PATHOLOGY	157
47.00	04700	ELECTROCARDIOLOGY	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	22
49.00	04900	DRUGS CHARGED TO PATIENTS	269
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0
51.00	05100	SUPPORT SURFACES	0
OUTPATIENT SERVICE COST CENTERS			
60.00	06000	CLINIC	0
61.00	06100	RURAL HEALTH CLINIC	0
62.00	06200	FOHC	0
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	0
71.00	07100	AMBULANCE	0
73.00	07300	CMHC	0
SPECIAL PURPOSE COST CENTERS			
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0
81.00	08100	INTEREST EXPENSE	0
82.00	08200	UTILIZATION REVIEW - SNF	0
83.00	08300	HOSPICE	0
89.00		SUBTOTALS (sum of lines 1-84)	609,903
NONREIMBURSABLE COST CENTERS			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	81
91.00	09100	BARBER AND BEAUTY SHOP	777
92.00	09200	PHYSICIANS PRIVATE OFFICES	0
93.00	09300	NONPAID WORKERS	0
94.00	09400	PATIENTS LAUNDRY	0
98.00		Cross Foot Adjustments	0
99.00		Negative Cost Centers	0
100.00		TOTAL	610,761

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315427

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

Worksheet B-1

Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	163,969				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0			2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	7,710,124		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	7,004	0	937,839	-2,968,841	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,827	0	373,447	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	2,233	0	75,557	0	6.00
7.00 00700	HOUSEKEEPING	1,015	0	469,835	0	7.00
8.00 00800	DIETARY	4,263	0	766,261	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	508	0	103,841	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	2,436	0	191,601	0	15.00
15.01 01501	CHAPLAIN	0	0	67,413	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	26,265	0	2,531,116	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	117,735	0	1,821,374	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	51,646	0	43.00
44.00 04400	PHYSICAL THERAPY	480	0	171,303	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	84,950	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	37,830	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
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	83.00
89.00	SUBTOTALS (sum of lines 1-84)	163,766	0	7,684,013	-2,968,841	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	26,111	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	203	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
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)	610,761	0	1,709,258	2,968,841	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	3.724857	0.000000	0.221690	0.248931	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0	26,089	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.002188	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315427

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

Worksheet B-1

Date/Time Prepared:
11/15/2021 2:32 pm

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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500	155,138					5.00
6.00	00600	2,233	467,000				6.00
7.00	00700	1,015	0	151,890			7.00
8.00	00800	4,263	0	4,263	157,604		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	508	0	508	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	2,436	0	2,436	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,265	350,250	26,265	63,501	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	117,735	116,750	117,735	94,103	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	480	0	480	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
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		154,935	467,000	151,687	157,604	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	203	0	203	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
98.00							98.00
99.00							99.00
102.00		1,537,420	170,256	897,799	2,668,987	0	102.00
103.00		9.910016	0.364574	5.910850	16.934767	0.000000	103.00
104.00		9,498	8,715	5,398	20,850	0	104.00
105.00		0.061223	0.018662	0.035539	0.132294	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315427

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

Worksheet B-1

Date/Time Prepared:
11/15/2021 2:32 pm

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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0	0				11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	0	21,167		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	21,167	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0		0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	21,167	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		0	0	0	114,939	0	102.00
103.00		0.000000	0.000000	0.000000	5.430103	0.000000	103.00
104.00		0	0	0	2,128	0	104.00
105.00		0.000000	0.000000	0.000000	0.100534	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315427

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

Worksheet B-1
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		OTHER GENERAL SERVICE			
		ACTIVITIES (PATIENT DAYS)	CHAPLAIN (PATIENT DAYS)		
		15.00	15.01		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3.00	00300	EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5.00
6.00	00600	LAUNDRY & LINEN SERVICE			6.00
7.00	00700	HOUSEKEEPING			7.00
8.00	00800	DIETARY			8.00
9.00	00900	NURSING ADMINISTRATION			9.00
10.00	01000	CENTRAL SERVICES & SUPPLY			10.00
11.00	01100	PHARMACY			11.00
12.00	01200	MEDICAL RECORDS & LIBRARY			12.00
13.00	01300	SOCIAL SERVICE			13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION			14.00
15.00	01500	ACTIVITIES	21,167		15.00
15.01	01501	CHAPLAIN	0	63,653	15.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	21,167	21,167	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	42,486	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	0	40.00
41.00	04100	LABORATORY	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	46.00
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
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC			62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
SPECIAL PURPOSE COST CENTERS					
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)	21,167	63,653	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
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)	389,792	103,334	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	18.415080	1.623396	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	9,925	181	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.468890	0.002844	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315427

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

Worksheet C

Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description			Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	6,643	4,671	1.422179	40.00
41.00	04100	LABORATORY	14,611	11,699	1.248910	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	83,429	55,351	1.507272	43.00
44.00	04400	PHYSICAL THERAPY	264,628	247,154	1.070701	44.00
45.00	04500	OCCUPATIONAL THERAPY	222,104	240,479	0.923590	45.00
46.00	04600	SPEECH PATHOLOGY	89,862	83,566	1.075342	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,764	10,220	1.248924	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	153,798	120,135	1.280210	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
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FOHC				62.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	847,839	773,275		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part I Date/Time Prepared: 11/15/2021 2:32 pm			
		Title XVIII (1)	Skilled Nursing Facility	PPS			
Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
		2.00	3.00	4.00	5.00		
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADIOLOGY	1.422179	4,400	0	6,258	0	40.00
41.00	04100 LABORATORY	1.248910	8,247	0	10,300	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1.507272	0	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	1.070701	141,168	0	151,149	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0.923590	146,420	0	135,232	0	45.00
46.00	04600 SPEECH PATHOLOGY	1.075342	55,298	0	59,464	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.248924	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.280210	111,594	0	142,864	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
OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0.000000	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC						61.00
62.00	06200 FQHC						62.00
71.00	07100 AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		467,127	0	505,267	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. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet D Parts II-III Date/Time Prepared: 11/15/2021 2:32 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST					
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		1.280210	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	6,643	0	0.000000	6,258	0	40.00
41.00	04100	LABORATORY	14,611	0	0.000000	10,300	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	83,429	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	264,628	0	0.000000	151,149	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	222,104	0	0.000000	135,232	0	45.00
46.00	04600	SPEECH PATHOLOGY	89,862	0	0.000000	59,464	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,764	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	153,798	0	0.000000	142,864	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)	847,839	0		505,267	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Parts I-III Date/Time Prepared: 11/15/2021 2: 32 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		21,167	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		2,339	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		6,924,193	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		9,277,765	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.746321	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		9,277,765	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		438.31	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		6,924,193	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		327.12	16.00
17.00	Program routine service cost (Line 3 times line 16)		765,134	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)		765,134	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)		135,769	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		6.41	21.00
22.00	Program capital related cost (Line 3 times line 21)		14,993	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		750,141	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)		750,141	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

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

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		21,167	1.00
2.00	Program inpatient days (see instructions)		2,339	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)		0.110502	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. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Parts I-III Date/Time Prepared: 11/15/2021 2: 32 pm
	Title XIX	Skilled Nursing Facility	Cost

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		21,167	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		10,761	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		6,924,193	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		9,277,765	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.746321	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		9,277,765	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		438.31	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		6,924,193	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		327.12	16.00
17.00	Program routine service cost (Line 3 times line 16)		3,520,138	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)		3,520,138	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)		135,769	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		6.41	21.00
22.00	Program capital related cost (Line 3 times line 21)		68,978	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		3,451,160	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)		3,451,160	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)		3,520,138	28.00

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

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		21,167	1.00
2.00	Program inpatient days (see instructions)		10,761	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)		0.508386	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part I Date/Time Prepared: 11/15/2021 2: 32 pm
		Title XVIII	Skilled Nursing Facility	PPS

		1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT			
1.00	Inpatient PPS amount (See Instructions)	1,445,330	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)	1,445,330	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinurance	227,539	5.00
6.00	Allowable bad debts (From your records)	7,986	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	5,191	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)	1,222,982	11.00
12.00	Interim payments (See instructions)	1,217,791	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)	5,191	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 - ANCI LLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY			
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	0	19.00
20.00	Medicare Part B ancillary charges (See instructions)	0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	0	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0	25.00
26.00	Interim payments (See instructions)	0	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	0	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part II Date/Time Prepared: 11/15/2021 2: 32 pm
		Title XIX	Skilled Nursing Facility	Cost
				1.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		3,520,138	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)		3,520,138	6.00
7.00	Differential in charges between semiprivate accommodations and less than semiprivate accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		3,520,138	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		3,520,138	10.00
REASONABLE CHARGES				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semiprivate accommodations and less than semiprivate accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315427	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Date/Time Prepared: 11/15/2021 2:32 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		1,217,791		0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0
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)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0
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)		1,217,791		0
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)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	PROGRAM TO PROVIDER		5,191		0
6.02	PROVIDER TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,222,982		0
			Contractor Name		Contractor Number
			1.00		2.00
8.00	Name of Contractor				

(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. : 315427

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

Worksheet G
Date/Time Prepared:
11/15/2021 2:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	93,778	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	1,604,483	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-370,500	0	0	0	6.00
7.00	Inventory	82,685	0	0	0	7.00
8.00	Prepaid expenses	113,204	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1,523,650	0	0	0	11.00
FIXED ASSETS						
12.00	Land	39,437	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	14,281,189	0	0	0	15.00
16.00	Less Accumulated depreciation	-11,803,153	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	1,969,628	0	0	0	19.00
20.00	Less: Accumulated depreciation	-1,319,425	0	0	0	20.00
21.00	Automobiles and trucks	171,892	0	0	0	21.00
22.00	Less: Accumulated depreciation	-171,892	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	3,167,676	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	714,070	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	714,070	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	5,405,396	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	596,092	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,182,235	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	12,500	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	671	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1,791,498	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	150,111	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	150,111	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	1,941,609	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,463,787	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	3,463,787	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	5,405,396	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315427

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

Worksheet G-1

Date/Time Prepared:
11/15/2021 2:32 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,455,830			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-992,041				2.00
3.00	Total (sum of line 1 and line 2)		3,463,789			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	INTERCOMPANY RECONCILIATION	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		3,463,789			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDING	2		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)		2			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		3,463,787			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)						4.00
5.00	INTERCOMPANY RECONCILIATION		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	ROUNDING		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. : 315427

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

Worksheet G-2
Parts I-11
Date/Time Prepared:
11/15/2021 2:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	9,277,765		9,277,765	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	7,317,952		7,317,952	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	16,595,717		16,595,717	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	712,622	0	712,622	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	17,308,339	0	17,308,339	14.00
Cost Center Description					
			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			15,794,012	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)			15,794,012	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315427

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

Worksheet G-3

Date/Time Prepared:
11/15/2021 2:32 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17,308,339	1.00
2.00	Less: contractual allowances and discounts on patients accounts	3,098,897	2.00
3.00	Net patient revenues (Line 1 minus line 2)	14,209,442	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	15,794,012	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,584,570	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	95,107	6.00
7.00	Income from investments	266	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	16,628	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	354	12.00
13.00	Revenue from laundry and linen service	108	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT REVENUE	372,273	24.00
24.01	CATERING / COUNTRY STORE	19,066	24.01
24.02	TRANS - RESIDENTIAL	5,508	24.02
24.03	UTILITY INCOME	450	24.03
24.06	HOUSEKEEPING	621	24.06
24.50	COVID-19 PHE Funding	82,151	24.50
25.00	Total other income (Sum of lines 6 - 24)	592,532	25.00
26.00	Total (Line 5 plus line 25)	-992,038	26.00
27.00	MISCELLANEOUS	3	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	3	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-992,041	31.00