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

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: 315364 Period: From 01/01/2021 Parts I, II & III To 12/31/2021 Date/Time Prepared			Exp11 03. 12/01/2021
5/19/2022 1:17 nm	Provi der CCN: 315364	From 01/01/2021	Parts I, II & III Date/Time Prepared:

		3/19/2022	i.i/ piii			
PART I - COST I	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	ort Date: 5/19/2022 Time:	1: 17 pr			
use only	y 2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	er the number of times the provider resubmitted this cost repo	rt			
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or Leave blank for no.				
Contractor	4.[1]Cost Report Status	6. Contractor No.				
use only	(1) As Submitted	7.[N] First Cost Report for this Provider CCN				
	(2) Settled without audit	8.[N] Last Cost Report for this Provider CCN				
	(3) Settled with audit	9. NPR Date:				
	(4) Reopened	10.[0]If line 4, column 1 is "4": Enter number of times reope	ened			
	(5) Amended	11. Contractor Vendor Code 4				
	5. Date Received:	12.[F] Medicare Utilization. Enter "F" for full, "L" for low, for no utilization.	or "N"			

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 JERSEY SHORE CENTER (315364) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Dia	ne Morris	l t	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	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1. 00	2.00	3. 00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	14, 005	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3. 00 ICF/IID				0	3. 00
4.00 SNF - BASED HHA I	0	0	0		4.00
5. 00 SNF - BASED RHC I	0		0		5. 00
6.00 SNF - BASED FQHC I	0		0		6. 00
7.00 SNF - BASED CMHC I	0		0		7. 00
7.10 SNF - BASED CORF I	0		0		7. 10
100. 00 TOTAL	0	14, 005	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.

KI LLE	Financial Systems D NURSING FACILITY AND SKILLED NURSING		EY SHORE CEI H CARE	NTER Provider No.		<u> </u>		u of Form Worksheet Part I		40-10
OMPLE)	X INDENTIFICATION DATA					To 12/31		Date/Time 5/19/2022		
	1.00		2. 00		3. 00			37 177 2022	1.17	рш
	Skilled Nursing Facility and Skilled N Street: 3 INDUSTRIAL WAY	lursing Facility PO Box:	/ Complex Ac	ldress:						1. 00
	City: EATONTOWN	State: N	IJ	Zi p Code: 07	724					2. 00
. 00	County: MONMOUTH		le: 35154	Urban/Rural	: U				1	3. 00
. 01		CBSA Cod				D 1	T-0	1.6.1	(D	3. 01
			Compor	nent Name	Provi der CCN	Date Certified	Payme	ent System O, or N)	(P,	
					0011	oci ti i i cu	V		XIX	
			1	. 00	2.00	3. 00	4. 00	5.00	5. 00	
- +	SNF and SNF-Based Component Identification SNF	ati on:	JERSEY SHOI	DE CENTED	315364	04/08/1997	N	P	P	4. 00
	Nursing Facility		JEKSET SHUI	KE CENTER	313364	04/06/199/	l iv			5. 00
	ICF/IID								İ	6. 00
	SNF-Based HHA									7. 00
	SNF-Based RHC									8.00
	SNF-Based FQHC SNF-Based CMHC								.	9.00
	SNF-Based OLTC									11. 00
	SNF-Based HOSPICE								-	12. 00
3. 00	SNF-Based CORF									13. 00
						From: 1.00		To:		
4. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/20	021	14. 00
. 00	Type of Control (See Instructions)						4			15. 00
								Y/N 1,00		
-	Type of Freestanding Skilled Nursing F	acility						1. 00		
	Is this a distinct part skilled nursing		meets the	requi rements	set forth	in 42 CFR		N		16. 00
	section 483.5?									
								N	1	17. 00
	42 CFR section 483.5? 0 Are there any costs included in Worksheet A that resulted from transactions with related									18. 00
	organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.									
	Miscellaneous Cost Reporting Information								40.00	
	Of If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.							N N		19. 00 19. 01
	Of If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare Nutilization cost report, indicate with a "Y", for yes, or "N" for no.								17.01	
Ī	Depreciation - Enter the amount of dep	reciation repor	ted in this	SNF for the	method in	dicated on	Li nes	20 - 22.		
	Straight Line							86		20.00
	Declining Balance Sum of the Year's Digits						-			21. 00 22. 00
	Sum of line 20 through 22							89		23. 00
4. 00	If depreciation is funded, enter the	balance as of t	he end of t	he peri od.			į		d 2	24. 00
	Were there any disposal of capital ass							N		25. 00
	Was accelerated depreciation claimed on (Y/N)	on any assets in	i the curren	t or any pri	or cost re	porting per	i od?	N	2	26. 00
1	Did you cease to participate in the Me	edicare program	at end of t	he period to	which this	s cost repo	rt	N	1	27. 00
	applies? (Y/N)			·		·				
	Was there a substantial decrease in he	ealth insurance	proporti on	of allowable	cost from	prior cost		N	1	28. 00
	reports? (Y/N)						Part	APart B 0	ther	
								2.00		
	If this facility contains a public or									
	of the lower of the costs or charges ϵ exemption.	enter "Y" for ea	ach componer	it and type o	or service	tnat qualif	res f	or the		
	Skilled Nursing Facility						N	N		29. 00
0. 00	Nursing Facility									30.00
	ICF/IID									31.00
	SNF-Based HHA						N	N N		32. 00 33. 00
	SNF-Based RHC SNF-Based FQHC							N N		34. 0
	SNF-Based CMHC							N		35. 00
	SNF-Based OLTC						L		3	36. 00
. 00						Y/N 1.00		2.00		
. 00						1.00		2. 00		
5. 00	Is the skilled nursing facility locate	nd in a state th	at certific	s the provid	er as a SNI					37 ∩
5. 00	Is the skilled nursing facility locate regardless of the level of care given				er as a SNI	Y			,	37. 00
7. 00 3. 00	regardless of the level of care given Are you legally-required to carry malp	for Titles V & bractice insuran	XIX patient ce? (Y/N)	s? (Y/N)	er as a SNI	N			3	38. 00
7. 00 3. 00	regardless of the level of care given Are you legally-required to carry malp Is the malpractice a "claims-made" or	for Titles V & practice insuran "occurrence" po	XIX patient ce? (Y/N) licy? If th	s? (Y/N)	er as a SNI				3	38. 00
7. 00 3. 00	regardless of the level of care given Are you legally-required to carry malp	for Titles V & practice insuran "occurrence" po	XIX patient ce? (Y/N) licy? If th	s? (Y/N)		N 1	sses	Self Insur	3	38. 00
7. 00 8. 00 9. 00	regardless of the level of care given Are you legally-required to carry malp Is the malpractice a "claims-made" or	for Titles V & practice insuran "occurrence" pos "occurrence",	XIX patient ce? (Y/N) licy? If th	s? (Y/N)	er as a SNI Premiums 1.00	N		Self Insur 3.00 0	ance	37. 00 38. 00 39. 00 41. 00

Heal th	Health Financial Systems JERSEY SHORE CENTER In Lieu					u of Form CMS-2	2540-10
SKI LLE	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315364 Period: N						
COMPLE	X INDENTIFICATION DATA				n 01/01/2021	Part I	
				То	12/31/2021	Date/Time Pre 5/19/2022 1:1	
						Y/N	/ pili
						1, 00	
42 00	Are malpractice premiums and paid loss	es reported in other than	the Administrat	ive and Gen	eral cost	N N	42.00
42.00	center? Enter Y or N. If yes, check bo					11	72.00
	amounts.	x, and submit supporting	seriedare rrating	, cost conto	n S unu		
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1. Ch	apter 10?			Υ	43. 00
	If line 43 is yes, enter the home offi			dress of th	e home	HB0067	44.00
	office on lines 45, 46 and 47.						
	1.00	2. 00			3. 00		
	If this facility is part of a chain or	ganization, enter the nam	ne and address of	the home c	office on the	lines	
	bel ow.						
45.00	Name: GENESIS HEALTHCARE	Contractor's Name: NOVITA	AS C	ontractor' s	Number: 1200	1	45. 00
46.00	Street: 101 EAST STATE STREET	PO Box:					46. 00
47. 00	City: KENNETT SQUARE	State: PA	Z	ip Code:	1934	8	47. 00

	Financial Systems	JERSEY SHORE CE				eu of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2021 Fo 12/31/2021	Worksheet S-2 Part II Date/Time Pre	epared:
					Y/N	5/19/2022 1:1 Date	i / piii
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	1, "Y" for	r Yes or "N" 1	1.00 For No. For all	2.00 the date	
1. 00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N 1. 00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and	in column	N		5, 5,	2. 00
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or relationships? (see instructions)	., chain home offic d to the provider o I, or members of the	es, drug r its e board	Y			3.00
				Y/N 1. 00	Type 2. 00	Date 3.00	
	Financial Data and Reports		5			J. 00	
4. 00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit completavailable in column 3. (see instructions) If	" for Audited, "C" te copy or enter da	for te	Y	С		4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.			N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2	: Is the	provider the	N	N	6.00
7. 00 8. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri	ng the cost reporti		for Nursing	N N		7. 00 8. 00
	School and/or Allied Health Program? (Y/N) so	ee Thstructrons.				Y/N 1.00	
9. 00 10. 00	Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb				t reporting	Y	9. 00
11. 00		d/or coi nsurance wa	ived? If "	Y", see instru	ucti ons.	N	11. 00
12. 00	Bed Complement Have total beds available changed from prior	cost reporting per	iod? If "Y	", see instru	ctions.	N	12.00
		Descriptio	n	Pa Y/N	rt A Date	Part B Y/N	
		0		1. 00	2. 00	3. 00	
13. 00	PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			N		N	13.00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			Y	03/19/2022	Y	14.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
	If line 13 or 14 is "Y", then were			N		N	17. 00
17. 00	adjustments made to PS&R data for Other? Describe the other adjustments:						

Heal th	Financial Systems JERS	SEY SHORE	RE CENTER In Lieu of			u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			Provi der		Peri od: From 01/01/2021 To 12/31/2021		pared:
						5/19/2022 1:1	/ pm
			1.	00	2.	00	
	Cost Report Preparer Contact Information						
	Enter the first name, last name and the title/position		EAN		PRI CE		19. 00
	held by the cost report preparer in columns 1, 2, and respectively.	d 3,					
20. 00	Enter the employer/company name of the cost report	GE	ENESIS HEALTH	CARE			20. 00
	preparer.	1					
	Enter the telephone number and email address of the	cost 41	108044481		JEAN. PRI CE@GEN	ESI SHCC. COM	21. 00
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems

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

JERSEY SHORE CENTER

In Lieu of Form CMS-2540-10

Provider No.: 315364
From 01/01/2021
To 12/31/2021
Part II
Date/Time Prepared:

Date/Time Prepared: 5/19/2022 1:17 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 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 03/19/2022 14.00 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 15.00 If line 13 or 14 is "Y", were adjustments 15.00 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. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: 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 REIMBURSEMENT ANALYST 19.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 20.00 20.00 preparer. 21.00 Enter the telephone number and email address of the cost 21.00

report preparer in columns 1 and 2, respectively.

Health Financial Systems JERSEY SHORE CENTER In Lieu of Form CMS-2540-10

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

Provider No.: 315364 | Period: Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared:

5/19/2022 1:17 pm Inpatient Days/Visits Title XVIII Component Number of Beds Bed Days Title V Title XIX Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 158 57, 670 6, 227 36, 657 1. 00 C NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 7.00 0 7.00 8.00 Total (Sum of lines 1-7) 158 57, 670 36, 657 8.00 Inpatient Days/Visits Di scharges Component 0ther Total Title V Title XVIII Title XIX 6.00 8.00 9. 00 10.00 SKILLED NURSING FACILITY 1.00 48, 518 230 1.00 5,634 66 NURSING FACILITY 2.00 2 00 0 0 3.00 ICF/IID 0 3.00 4.00 HOME HEALTH AGENCY COST 0 4.00 Other Long Term Care SNF-Based CMHC 0 5.00 5.00 6.00 6 00 6.10 SNF-Based CORF 6.10 HOSPI CE 7.00 7.00 Total (Sum of lines 1-7) 8.00 5.634 48, 518 230 8.00 66 Average Length of Stay Di scharges 0ther Title V Title XVIII Title XIX Component Total 11. 00 13.00 14.00 15.00 12.00 1.00 SKILLED NURSING FACILITY 0. 00 27. 07 555. 41 1.00 236 532 2.00 NURSING FACILITY 0.00 0.00 2.00 ICF/IID 0 3.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 0.00 0.00 7 00 0 00 7 00 Total (Sum of lines 1-7) 0.00 8.00 236 532 27.07 555.41 8.00 Average Length Admi ssi ons of Stay Component Title V Title XVIII 0ther Title XIX Total 18.00 19.00 20.00 16.00 17.00 1.00 SKILLED NURSING FACILITY 91. 20 278 21 240 1.00 2.00 NURSING FACILITY 0.00 0 2.00 0 ICF/IID 3.00 0.00 3.00 0 0 HOME HEALTH AGENCY COST 4 00 4 00 5.00 Other Long Term Care 0.00 5.00 6.00 SNF-Based CMHC 6.00 6.10 SNF-Based CORF 6.10 7.00 HOSPI CE 0.00 Γ Λ 7.00 91. 20 Total (Sum of lines 1-7) 240 8.00 278 21 8.00 Admi ssi ons Full Time Equivalent Component Total Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 539 105. 50 0.00 1. 00 NURSING FACILITY 0.00 0.00 2.00 2.00 3.00 LCF/LLD 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0.00 0.00 5.00 SNF-Based CMHC 0.00 0.00 6.00 6.00 6.10 SNF-Based CORF 0.00 0.00 6. 10 7.00 HOSPI CE 0.00 0.00 7.00 Total (Sum of lines 1-7) 539 105.50 0.00 8.00 8.00

SNF WAGE INDEX INFORMATION

Provi der No.: 315364

Peri od: Worksheet S-3 From 01/01/2021 Part II

12/31/2021 Date/Time Prepared: 5/19/2022 1:17 pm Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Reported Wage (col. 3 ÷ col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 6, 211, 958 6, 211, 958 219, 431. 00 28. 31 1.00 Physician salaries-Part A 0.00 2.00 0 0 0 0.00 2.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 3.00 Home office personnel 0 0 0 0.00 4.00 0.00 4.00 Sum of lines 2 through 4 0 0.00 5.00 0 0.00 5.00 0 0 219, 431. 00 6.00 Revised wages (line 1 minus line 5) 6, 211, 958 6, 211, 958 28.31 6.00 7.00 Other Long Term Care 0 0 0.00 0.00 7.00 HOME HEALTH AGENCY COST 8.00 0 0 0.00 0.00 8.00 0 9.00 CMHC 0 0.00 0.00 9.00 9.10 CORF 9. 10 10.00 HOSPI CE 0.00 0.00 10.00 Other excluded areas 0 0 0 0.00 0.00 11.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 12.00 0.00 0.00 12.00 through 11) 13.00 Total Adjusted Salaries (line 6 minus line 6, 211, 958 6, 211, 958 219, 431. 00 28. 31 13.00 OTHER WAGES & RELATED COSTS 43. 21 14.00 Contract Labor: Patient Related & Mgmt 2, 252, 252 2, 252, 252 52, 124. 86 14.00 15.00 Contract Labor: Physician services-Part A 51, 900 0 51, 900 610.00 85. 08 15.00 16.00 Home office salaries & wage related costs 661, 502 0 661, 502 12, 350. 00 53.56 16.00 WAGE-RELATED COSTS Wage-related costs core (See Part IV) 1, 031, 559 17.00 17.00 1, 031, 559 Wage-related costs other (See Part IV) 0 18.00 0 0 19.00 Wage related costs (excluded units) 0 0 19.00 Physician Part A - WRC Physician Part B - WRC 20.00 0 0 0 20.00 21.00 0 21.00 Total Adjusted Wage Related cost (see 1, 031, 559 1, 031, 559 22.00 22.00 instructions)

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 |

				'	0 12/31/2021	5/19/2022 1:1	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
		·	Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1. 00
2.00	Administrative & General	446, 757	0	446, 757	12, 566. 00	35. 55	2. 00
3.00	Plant Operation, Maintenance & Repairs	122, 193	0	122, 193	4, 319. 00	28. 29	3. 00
4.00	Laundry & Linen Service	0	0	C	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	C	0.00	0.00	5. 00
6.00	Di etary	0	0	C	0.00	0.00	6. 00
7.00	Nursing Administration	616, 334	-36, 244	580, 090	15, 525. 00	37. 36	7. 00
8.00	Central Services and Supply	0	0	C	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	36, 244	36, 244	1, 563. 00	23. 19	10. 00
11. 00	Soci al Servi ce	185, 831	0	185, 831	7, 068. 00	26. 29	11. 00
12.00	Nursing and Allied Health Ed. Act.						12. 00
13.00	Other General Service	138, 785	0	138, 785	8, 427. 00	16. 47	13. 00
14.00	Total (sum lines 1 thru 13)	1, 509, 900	0	1, 509, 900	49, 468. 00	30. 52	14. 00

Health Financial Systems	JERSEY SHORE CENTER	In Lie	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315364	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/19/2022 1:17 pm

	To 12/31/2021	Date/Time Pre 5/19/2022 1:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		İ
	RETIREMENT COST		İ
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4. 00	Prior Year Pension Service Cost	0	4.00
1. 00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1.00
5.00	401K/TSA Plan Administration fees	0	5.00
6. 00	Legal /Accounting/Management Fees-Pensi on Plan	0	6.00
7. 00	Employee Managed Care Program Administration Fees	0	7.00
7.00	HEALTH AND INSURANCE COST		7.00
8. 00	Health Insurance (Purchased or Self Funded)	297, 446	8.00
			1
9.00	Prescription Drug Plan	0	
10.00	Dental, Hearing and Vision Plan	0	
11. 00		0	11.00
12. 00		0	1
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14. 00		0	
15.00		188, 347	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	452, 976	17. 00
18.00		0	18. 00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	79, 040	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	13, 750	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 031, 559	
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
	1	'	

					rom 01/01/2021	Part V	
				T	o 12/31/2021	Date/Time Pre	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	5/19/2022 1:1 Average Hourly	/ pili
	occupational category	Reported		Salaries (col.		Wage (col. 3 ÷	
		Reported	Delle I I IS		Salary in col.	col. 4)	
				1 + COI. 2)	2	COI . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	Di rect Sal ari es	1.00	2.00	3.00	4.00	3.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 310, 606	200, 867	1, 511, 473	32, 801. 00	46. 08	1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 299, 445	206, 442		i i		2. 00
3.00	Certified Nursing Assistant/Nursing	2, 092, 007	382, 004		i i		3. 00
	Assi stants/Ai des	, ,	,	,	, , , , , , , , , , , , , , , , , , , ,		
4.00	Total Nursing (sum of lines 1 through 3)	4, 702, 058	789, 313	5, 491, 371	169, 963. 00	32. 31	4. 00
5.00	Physical Therapists	0	0	0	0.00	0.00	5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6. 00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7. 00
8.00	Occupational Therapists	o	0	0	0.00	0.00	8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9. 00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11. 00
12.00	Respi ratory Therapi sts	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00		27, 614		27, 614			
15. 00		170, 833		170, 833			15.00
16. 00	Certified Nursing Assistant/Nursing	49, 931		49, 931	1, 160. 03	43. 04	16. 00
	Assi stants/Ai des						
17. 00		248, 378		248, 378			
18. 00	Physical Therapists	182, 066		182, 066			
19. 00		107, 652		107, 652			
20. 00	Physical Therapy Aides	0		0	0.00	0. 00	
21. 00	Occupational Therapists	279, 447		279, 447			21. 00
22. 00	Occupational Therapy Assistants	113, 242		113, 242	i i		22. 00
23. 00	Occupational Therapy Aides	0		0	0.00	0.00	23. 00
24. 00	Speech Therapists	116, 078		116, 078			24. 00
25. 00	Respiratory Therapists	24, 916		24, 916			25. 00
26.00	Other Medical Staff	51, 900		51, 900	610.00	85.08	26. 00

From 01/01/2021 12/31/2021 Date/Time Prepared: 5/19/2022 1:17 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 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 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 30.00 HD1 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 44.00 CE1 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 52.00 CA1 SE3 53.00 53.00 54.00 SE2 54.00 55.00 SE1 55.00 SSC 56.00 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 PE1 68.00 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

Health Financial Systems	JERSEY SHORE CENTER		In Lieu of Form CMS-2540-10				
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315364	Peri od:	Worksheet S-7	'		
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 1:1			
			Group	Days			
			1. 00	2. 00			
76. 00			PA1		76. 00		
99. 00			AAA		99. 00		
100. 00 TOTAL		1			100. 00		
		Expenses	Percentage	Y/N			
		1.00	2. 00	3. 00			
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, Line	1, column 3)				101. 00 102. 00 103. 00 104. 00 105. 00 106. 00		

Heal th	Financial Systems	JERSEY SHORE	CENTER		In Lie	u of Form CMS-2	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	pared.
						5/19/2022 1:1	
	Cost Center Description	Sal ari es	0ther	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	1 Reclassi ficati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
					Increase/Decre	V	
					ase (Fr Wkst A-6)	col . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	11.99		2.22		9.77	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		2, 844, 356	2, 844, 35	6 0	2, 844, 356	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0		0	0	2. 00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 022, 769	1		1, 022, 769	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	446, 757	2, 998, 450	1		3, 445, 207	4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	122, 193	358, 313 306, 988	1		480, 506 306, 988	5. 00 6. 00
7. 00	00700 HOUSEKEEPING		231, 562	1		231, 562	7.00
8. 00	00800 DI ETARY	0	985, 041	1		985, 041	8. 00
9. 00	00900 NURSING ADMINISTRATION	616, 334	19, 795	1		599, 885	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	47, 678	47, 67		47, 678	10.00
11. 00	01100 PHARMACY	0	0		0	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0)	0 36, 244	36, 244	12.00
13.00	01300 SOCIAL SERVICE	185, 831	12	185, 84	.3 0	185, 843	
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	120 705	22 214	170.00	0	172.000	14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	138, 785	33, 314	172, 09	9 0	172, 099	15. 00
30. 00	03000 SKILLED NURSING FACILITY	4, 702, 058	475, 969	5, 178, 02	7 0	5, 178, 027	30.00
31. 00	03100 NURSING FACILITY	0	0)	0 0	0, 1, 0, 02,	31.00
32.00	03200 CF/IID	0	0		0 0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	O	0		0 0	0	33. 00
	ANCILLARY SERVICE COST CENTERS				_1		
40.00	04000 RADI OLOGY	0	18, 640	1			40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	31, 671 38, 334	1		31, 671 38, 334	
43. 00	04300 OXYGEN (INHALATION) THERAPY		42, 719	1		42, 719	42.00
44. 00	04400 PHYSI CAL THERAPY		322, 723	1		322, 723	1
45. 00	04500 OCCUPATI ONAL THERAPY	o	307, 445	1		307, 445	45. 00
46.00	04600 SPEECH PATHOLOGY	0	170, 087	170, 08	7 0	170, 087	46. 00
47. 00	04700 ELECTROCARDI OLOGY	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	354, 221	354, 22	0	354, 221	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	55, 829	55, 82	0 0	0 55, 829	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS		55, 62 9	35, 62	0 0	0.00	52.00
02.00	OUTPATIENT SERVICE COST CENTERS	0		′1	<u> </u>		02.00
60.00	06000 CLI NI C	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	61. 00
62. 00	06200 FQHC		_			_	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0)	0 0	0	63. 00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70. 00
	07100 AMBULANCE		0		0 0	0	71.00
72. 00	07200 CORF		0	ó	0 0	Ö	72.00
73. 00	07300 CMHC	0	0		0 0	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	O	0		0 0	0	74. 00
	SPECIAL PURPOSE COST CENTERS			. [_1		
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0)	0	0	80.00
81.00	08100 INTEREST EXPENSE		0		0	0	81.00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE		0		0	0 0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS		0		0 0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	6, 211, 958	10, 665, 916	16, 877, 87	4 0	16, 877, 874	89. 00
	NONREI MBURSABLE COST CENTERS				•	<u> </u>	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0)	0 0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	3, 043	3, 04	3 0	3, 043	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	2	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0			0 0	93. 00 94. 00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS		0	á		0	95.00
100.00		6, 211, 958	10, 668, 959	16, 880, 91	7 0	16, 880, 917	
	To the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the		.,		, 9		

JERSEY SHORE CENTER In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 JERSEY

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315364 | Period: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				To 12/31/2021	
	Cost Center Description	Adjustments to	Net Expenses		5/19/2022 1:17 pm
	, , , , , , , , , , , , , , , , , , ,		For Allocation		
		Wkst A-8)	(col. 5 +-		
		6.00	col . 6) 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	2, 844, 356		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	l .		2. 00
3.00	00300 EMPLOYEE BENEFITS	86, 389		•	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-1, 417, 229		1	4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	480, 506 306, 988	•	5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG		231, 562	•	7. 00
8. 00	00800 DI ETARY	0	985, 041	•	8.00
9.00	00900 NURSING ADMINISTRATION	0	599, 885		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	47, 678	1	10. 00
11.00	01100 PHARMACY	0	0	1	11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	36, 244 185, 843	•	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0	•	14. 00
	01500 ACTI VI TI ES	-21, 421	-	1	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 SKILLED NURSING FACILITY	1, 039		1	30.00
31. 00	03100 NURSING FACILITY	0	0	•	31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE		0	•	32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS)		33.00
40. 00	04000 RADI OLOGY	0	18, 640		40. 00
41.00	04100 LABORATORY	0	31, 671		41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	38, 334	1	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	42, 719	•	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	322, 723 307, 445	•	44. 00 45. 00
	04600 SPEECH PATHOLOGY		170, 087	•	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	1	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	354, 221	1	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVICE COST CENTERS		55, 829 0	•	51. 00 52. 00
32.00	OUTPATIENT SERVICE COST CENTERS		,		32. 00
60.00	06000 CLI NI C	0	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		61.00
62.00	06200 FQHC				62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0		63. 00
70. 00	07000 HOME HEALTH AGENCY COST		0		70.00
	07100 AMBULANCE	0	Ö	•	71. 00
72. 00	07200 CORF	0	0		72. 00
	07300 CMHC	0	0		73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0) 0		74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		80. 00
81. 00	08100 NTEREST EXPENSE			•	81. 00
82. 00	08200 UTI LI ZATI ON REVI EW	0	o o		82. 00
83. 00	08300 H0SPI CE	0	0		83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 351, 222	15, 526, 652		89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN) 0		90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		3, 043	1	91. 00
	09200 PHYSICIANS PRIVATE OFFICES		0	1	92. 00
	09300 NONPALD WORKERS	0	0		93. 00
	09400 PATIENTS LAUNDRY	0	0		94.00
95. 00 100. 00	O9500 OTHER NONREIMBURSABLE COST CENTERS TOTAL	-1, 351, 222	0 2 15, 529, 695		95. 00 100. 00
100.00	I LIVIAL	-1,301,222	15,527,095	TI	1100.00

Health Financial Systems	JERSEY SHORE CE	NTER		In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS			Peri od: From 01/01/2021	Worksheet A-6			
				To 12/31/2021	Date/Time Pre 5/19/2022 1:1		
	Increases						
	Cost Center		Li ne #	Sal ary	Non Salary		
	2.00		3. 00	4. 00	5. 00		
(1) A - DEFAULT							
1. 00	MEDICAL RECORDS & L	J BRARY	12. 0	36, 244	0	1. 00	
TOTALS							
100.00	Total Reclassificat	ions (Sum		36, 244	0	100. 00	
	of columns 4 and 5 must						
	equal sum of column	equal sum of columns 8 and					
	9)						

⁽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.

Health Financial Systems	JERSEY SHORE CENTER			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provi der No.: 315364			Worksheet A-6		
			From 01/01/2021 To 12/31/2021	Date/Time Prep 5/19/2022 1:1			
	Decreases						
	Cost Cente	r	Li ne #	Sal ary	Non Salary		
	6.00		7. 00	8. 00	9. 00		
(1) A - DEFAULT							
1.00	NURSING ADMINISTRAT	I ON	9. 0	0 36, 244	0	1.00	
TOTALS						l	
100. 00				36, 244	0	100. 00	

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

| Period: | Worksheet A-7 | From 01/01/2021 | To 13/21/2021 | Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS JERSEY SHORE CENTER Provi der No.: 315364

					To 12/31/2021	Date/Time Prep 5/19/2022 1:17	pared:
			<u> </u>	Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	1	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5				I	
1.00	Land	0	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3. 00
4.00	Building Improvements	341, 484	204, 135		0 204, 135		4. 00
5.00	Fi xed Equi pment	99, 505	37, 391		0 37, 391		5. 00
6. 00	Movable Equipment	854, 686	47, 619		0 47, 619		6. 00
7.00	Subtotal (sum of lines 1-6)	1, 295, 675	289, 145		0 289, 145		7. 00
8.00	Reconciling Items	1, 295, 675	0		0	0	8. 00
9.00	9.00 Total (line 7 minus line 8)		289, 145		0 289, 145	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		7.00				
1. 00	Land	<u> </u>	0				1. 00
2. 00	Land Improvements		0				2. 00
3. 00	Buildings and Fixtures		0				3. 00
4. 00	Building Improvements	545, 619	0				4. 00
5. 00	Fi xed Equi pment	136, 896	0				5. 00
6. 00	Movable Equipment	902, 305	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	1, 584, 820	0				7. 00
8. 00	Reconciling Items	1, 304, 020	0				8. 00
9. 00	Total (line 7 minus line 8)	1, 584, 820	0				9. 00
,. 55	11222 (1110)	., 55., 520	O	ı			,, 55

Provi der No.: 315364

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

				To 12/31/2021	Date/Time Prep 5/19/2022 1:1	pared:
				Expense Classification on		/ pili
				To/From Which the Amount is		
				TO, I TO MINIOUS TITE THIS GIVE TO	to bo haj dotod	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	(.)	Adjustment				
		1.00	2. 00	3.00	4. 00	
1.00	Investment income on restricted funds		C		0.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		C		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)	İ	C		0.00	3. 00
4.00	Rental of provider space by suppliers	İ	C		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		C		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)	A	-21, 421	ACTI VI TI ES	15.00	6. 00
7.00	Parking Lot (chapter 21)		C		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	C			8. 00
	physi ci an adjustment					
9.00	Home office cost (chapter 21)		C		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	10.00
11. 00	Nonallowable costs related to certain		C		0.00	11. 00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	-143, 829			12.00
	related organizations (chapter 10)					
13.00	Laundry and Linen service		C		0.00	13.00
14.00	Revenue - Employee meals		C		0.00	14.00
15.00	Cost of meals - Guests		C		0.00	15. 00
16.00	Sale of medical supplies to other than		C		0.00	16.00
	patients					
17.00	Sale of drugs to other than patients		C		0.00	17.00
18.00	Sale of medical records and abstracts		C		0.00	18.00
19.00	Vendi ng machi nes		C		0.00	19.00
20.00	Income from imposition of interest, finance		C		0.00	20.00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		C		0.00	21.00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		C	UTILIZATION REVIEW	82.00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		C	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		C	CAP REL COSTS - MOVABLE	2.00	24. 00
				EQUI PMENT		
25. 00	MI SC I NCOME	В		ADMINISTRATIVE & GENERAL	4.00	25.00
25. 01	UNALLOWED A & G	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	WORKERS COMPENSATION	A		EMPLOYEE BENEFITS	3.00	25. 02
25. 03	HEP/SALI NE	A	1, 039	SKILLED NURSING FACILITY	30.00	25. 03
100.00	Total (sum of lines 1 through 99) (Transfer		-1, 351, 222	2		100. 00
	to Worksheet A, col. 6, line 100)					
(4) D			CMC Dule 1F 1	1		

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

JERSEY SHORE CENTER

Health Financial Systems JERSEY SHORE STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS Provider No.: 315364 | Period: | Worksheet A-8-1 | From 01/01/2021 | Parts I-II

DFFICE COSTS				o 12/31/2021 Date	ts I-II e/Time Prepared:
	Line No.	Cost	 Center	Expense I te	9/2022 1:17 pm ems
	1. 00	2.	00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	4. 00 44. 00 45. 00 46. 00 30. 00 43. 00	ADMI NI STRATI VE ADMI NI STRATI VE PHYSI CAL THERA OCCUPATI ONAL T SPEECH PATHOLO SKILLED NURSI N OXYGEN (I NHALA ADMI NI STRATI VE	& GENERAL PY HERAPY GY G FACILITY TION) THERAPY	HOME OFFICE A&G HOME OFFICE CAPITAL PT OT ST NURSING PURCHASED S RT MEDICAL DIRECTOR	3. 00 4. 00 5. 00
9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	0. 00			MEDICAL DIRECTOR	9. 00 10. 00
	Amount	Amount	Adjustments		
	Allowable In Cost	Included in Wkst. A, col.	(col. 4 minus col. 5)		
	4. 00	5. 00	6. 00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1. 00 2. 00 3. 00	852, 219 52, 539 322, 481	0	52, 539		1. 00 2. 00 3. 00
4. 00 5. 00	305, 926 170, 079	305, 926	c		4. 00 5. 00
5. 00 7. 00	248, 378 31, 561		1		6. 00 7. 00
3.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column	51, 900 0 2, 035, 083	0	c		8. 00 9. 00 10. 00
6, line 100 to Worksheet A-8, column 3, line 12.	2, 000, 000	2, 170, 712	143, 027		10.00

Provider No.: 315364 OFFICE COSTS

Peri od: Worksheet A-8-1 From 01/01/2021 12/31/2021

Parts I-II Date/Time Prepared: 5/19/2022 1:17 pm

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

1.00	В	0.00	1.00
2. 00	В	0.00	2. 00
3. 00	В	0.00	3. 00
4. 00	В	0.00	4. 00
5. 00	В	0.00	5. 00
6. 00		0.00	6. 00
7. 00		0.00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100. 00
speci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in rel ated organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Rel ated Organi	Related Organization(s) and/or Home Office						
	Name	Percentage of	Type of Business					
		Ownershi p						
	4. 00	5. 00	6.00					
DADT II INTERRELATIONSHIP TO RELATER ORGANI	TATLONICO AND COD HOME OFFICE			-				

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2. 00		GRS	100.00	PT OT ST	2.00
3. 00		GSS	100.00	NURSING PURCHASED SERVICES	3.00
4.00		RHS	100.00	RT	4.00
5.00		GPS	100.00	MEDICAL DIRECTOR	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 (fin	ancial or non-financial)		0.00		100. 00
speci fy:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

NTER In Lieu of Form CMS-2540-10
Provider No.: 315364 Period: Worksheet B
From 01/01/2021 Part I
12/21/2021 Part I
12/21/2021 Part I
12/21/2021 Part I
12/21/2021 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

						To	12/31/2021	Date/Time Pre	
				CAPI TAL REL	ATED COSTS			5/19/2022 1:1	/ pm
		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FIXTURES	MOVABLE EQUI PMENT		EMPLOYEE BENEFITS	Subtotal	
			0	1. 00	2. 00		3. 00	3A	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	2, 844, 356	2, 844, 356		_			1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	00200 00300 00400 00500 00600 00700 00800 00900	CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION	0 1, 109, 158 2, 027, 978 480, 506 306, 988 231, 562 985, 041 599, 885	281, 468 175, 934 54, 277 17, 728 289, 369 66, 931		0 0 0 0 0 0 0	1, 109, 158 79, 769 21, 818 0 0 0 103, 576	2, 389, 215 678, 258 361, 265 249, 290 1, 274, 410 770, 392	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY	47, 678	0		0	0	47, 678 0	10. 00 11. 00
12. 00 13. 00 14. 00 15. 00	01200 01300 01400 01500	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION ACTIVITIES JENT ROUTINE SERVICE COST CENTERS	36, 244 185, 843 0 150, 678	15, 801 24, 023 0 111, 315		0 0 0 0	6, 471 33, 180 0 24, 780	58, 516 243, 046 0 286, 773	12. 00
30. 00		SKILLED NURSING FACILITY	5, 179, 066	1, 568, 564		0	839, 564	7, 587, 194	30. 00
31. 00 32. 00 33. 00	03100 03200 03300	NURSING FACILITY ICF/IID OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0 0	0 0		0 0 0	0 0 0 0	0 0	31. 00 32. 00 33. 00
40. 00		RADI OLOGY	18, 640	0		0	0	18, 640	40. 00
41. 00 42. 00 43. 00 44. 00	04200 04300	LABORATORY INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	31, 671 38, 334 42, 719 322, 723	0 0 0 93, 202		0 0 0 0	0 0 0 0	31, 671 38, 334 42, 719 415, 925	41. 00 42. 00 43. 00 44. 00
45. 00 46. 00 47. 00 48. 00	04600 04700	OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	307, 445 170, 087 0	58, 002 4, 368 0 10, 149		0 0 0	0 0 0	365, 447 174, 455 0 10, 149	45. 00 46. 00 47. 00 48. 00
49. 00 50. 00 51. 00 52. 00	04900 05000 05100	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES OTHER ANCILLARY SERVICE COST CENTERS	354, 221 0 55, 829 0	73, 225 0 0 0		0 0 0	0 0 0	427, 446 0 55, 829 0	49. 00 50. 00 51. 00 52. 00
02.00		TIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		<u> </u>	<u> </u>	0	02.00
60. 00 61. 00 62. 00 63. 00	06100 06200	CLINIC RURAL HEALTH CLINIC FOHC OTHER OUTPATIENT SERVICE COST CENTER	0	0 0 0		0	0 0	0	60. 00 61. 00 62. 00 63. 00
00.00		REI MBURSABLE COST CENTERS	-1	٩			٥,	Ü	00.00
70. 00 71. 00 72. 00 73. 00 74. 00	07100 07200 07300 07400	CMHC OTHER REIMBURSABLE COST	0 0 0 0 0	0 0 0 0 0		0 0 0 0	0 0 0 0 0	0 0 0 0	
80. 00 81. 00 82. 00 83. 00	08000 08100 08200 08300	AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE UTILIZATION REVIEW HOSPICE	0	0		0	0	0	80. 00 81. 00 82. 00 83. 00
84. 00 89. 00	NONRE	OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS	0 15, 526, 652	0 2, 844, 356		0	0 1, 109, 158	0 15, 526, 652	84. 00 89. 00
90. 00 91. 00 92. 00 93. 00 94. 00 95. 00 98. 00	09100 09200 09300 09400	GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES NONPAID WORKERS PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0 3,043 0 0 0	0 0 0 0 0		0 0 0 0 0	0 0 0 0 0 0	0 3, 043 0 0 0 0	90. 00 91. 00 92. 00 93. 00 94. 00 95. 00 98. 00
99. 00 100. 00		Negative Cost Centers TOTAL	0 15, 529, 695	0 2, 844, 356		0	0 1, 109, 158	0 15, 529, 695	99. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315364

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/19/2022 1:17 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 2, 389, 215 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 123, 322 801, 580 5.00 00600 LAUNDRY & LINEN SERVICE 65,686 18, 227 445, 178 6.00 6.00 00700 HOUSEKEEPI NG 7.00 45, 326 5, 953 0 300, 569 7.00 8.00 00800 DI ETARY 231, 715 97, 175 0 37, 571 1, 640, 871 8.00 9.00 00900 NURSING ADMINISTRATION 140,073 22, 476 0 8, 690 9.00 Ω 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 8,669 C Ω 11.00 01100 PHARMACY r 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 10,639 5. 306 2.052 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 44.191 8.067 0 3, 119 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 01500 ACTI VI TI ES 52, 141 37, 382 14, 453 0 15.00 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 203, 660 1, 640, 871 30.00 1, 379, 511 526, 752 445, 178 31.00 03100 NURSING FACILITY 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 3, 389 0 0 0 0 40.00 41.00 04100 LABORATORY 5,758 0 0 0 41.00 6, 970 42 00 04200 I NTRAVENOUS THERAPY Ω 0 0 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 7,767 C 0 0 43.00 04400 PHYSI CAL THERAPY 75, 624 31, 299 12, 101 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 66, 446 19, 478 0 7,531 0 45.00 04600 SPEECH PATHOLOGY 46 00 31, 720 0 46 00 1, 467 567 0 04700 ELECTROCARDI OLOGY 47.00 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,845 3, 408 1, 318 48.00 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 77, 719 24, 590 0 9.507 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 50.00 C 0 0 51.00 05100 SUPPORT SURFACES 10, 151 C 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 60.00 06000 CLI NI C 0 Ω 0 0 0 06100 RURAL HEALTH CLINIC 61.00 0 0 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 07200 CORF 0 0 0 72.00 0 0 72.00 0 73.00 07300 CMHC 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSABLE COST 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 08300 H0SPLCE 83.00 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 2, 388, 662 801, 580 445, 178 300, 569 1, 640, 871 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 Λ 90 00 91.00 09100 BARBER AND BEAUTY SHOP 553 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 92.00 0 0 09300 NONPALD WORKERS 0 93.00 93.00 0 0 09400 PATI ENTS LAUNDRY 0 0 0 94.00 C 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 C 0 0 0 98.00 99 00 Negative Cost Centers 99 00 0 0 0 100.00 **TOTAL** 2, 389, 215 801, 580 445, 178 300, 569 1, 640, 871 100. 00

Provi der No.: 315364

					10 12/31/2021	5/19/2022 1:1	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	, piii
		9.00	10.00	11. 00	12. 00	13.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION	941, 631					5. 00 6. 00 7. 00 8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	56, 347				10.00
11. 00	01100 PHARMACY	0	0		0		11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 76, 513	1	12.00
13.00	01300 SOCIAL SERVICE	0	0		0	298, 423	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14.00
15. 00	01500 ACTIVITIES	0	0		0 0	0	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	041 (21	F/ 247	I	0 /7 200	200 422	1 20 00
30.00	03000 SKI LLED NURSI NG FACILITY	941, 631	56, 347		0 67, 300	•	30.00
31. 00	03100 NURSING FACILITY	0	0		0	0	31.00
32.00	03200 I CF/IID	0	0			0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	l ol	0		U _I	0	33. 00
40. 00	04000 RADI OLOGY	l ol	0		0 118	0	40. 00
41. 00	04100 LABORATORY		0		0 270		41.00
42. 00	04200 I NTRAVENOUS THERAPY		0		0 89	1	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0		0 81	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	o	0		0 2, 820	1	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	o	0		0 2, 870	1	45. 00
46.00	04600 SPEECH PATHOLOGY	o	0		0 1, 520	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	o	0		0 0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0 0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 1, 108	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		0 337	1	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS	1		1			,
60.00	06000 CLINIC	0	0		0	1	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		0 0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0			0	63.00
03.00	OTHER REIMBURSABLE COST CENTERS	l d	0		U C	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	l ol	0		0 0	0	70.00
71. 00	07100 AMBULANCE		0		0 0	ő	71.00
72. 00	07200 CORF	o	0		0	o o	72. 00
73.00	07300 CMHC	o	0		0 0	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	o	0		0 0	0	74.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW						82. 00
83. 00	08300 H0SPI CE	0	0		0 0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	941, 631	56, 347		0 76, 513	298, 423	89. 00
00.00	NONREI MBURSABLE COST CENTERS	1 2					00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0		90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP	0	0			0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0		0 0	0	92. 00 93. 00
94.00	09400 PATI ENTS LAUNDRY		0			0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		0			0	95.00
98. 00	Cross Foot Adjustments		0				98. 00
99. 00	Negative Cost Centers		0		0 0	0	99. 00
100.00		941, 631	56, 347		0 76, 513		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315364

Cuest Center Description						-rom 01/01/2021 Γο 12/31/2021	Part I Date/Time Pre	
COST CENTER DESCRIPTION				OTHER GENERAL			5/19/2022 1:1	/ pm
BERNARIA SERVICE COST CENTERS		Cost Center Description	ALLI ED HEALTH		Subtotal		Total	
0.000 CORP REL COSTS - BLOGS S FIXTURES		CENEDAL CEDULCE COCT CENTEDO	14.00	15. 00	16. 00	17.00	18. 00	
30.00	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	-	390, 749				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
32.00 03200 CIFF I NOW TERM CARE		03000 SKILLED NURSING FACILITY		1				
33. 00 03300 OTHER LONG TENI CARE 0 0 0 0 0 33. 00				-	•	1 1		1
40.00 04000 RADI OLOGY		1 1	·	ı,	•	- 1		1
11 00	40.00			ما	22.14	7 0	22 147	10.00
42.00 04200 INTRAVENOUS THERAPY 0 0 45, 393 0 45, 393 42, 00 44.00 04400 PHYSI CAL THERAPY 0 0 0 50, 567 0 50, 567 43.00 44.00 04400 PHYSI CAL THERAPY 0 0 0 50, 567 0 50, 567 43.00 44.00 04400 PHYSI CAL THERAPY 0 0 0 461, 772 0 461, 772 45.00 44.00 04600 SOPECH PATHOLOGY 0 0 0 0 209, 729 0 209, 729 0 46.00 04600 SOPECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0			1		,		· ·	1
44.00 04400 PHYSI CAL THERAPY 0 0 537, 769 0 537, 769 44.00			1	o	- ,			
45.00 04500 04500 04500 04500 04500 04500 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600 04600			o	0		1		1
44.00 04600 SPEECH PATHOLOGY 0 0 209,729 0 209,729 46.00 47.00 04700 ELCETROCARDI OLOGY 0 0 0 0 0 0 0 48.00 04900 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 16,720 0 16,720 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 540,370 0 540,370 0 540,370 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 51.00 05100 DEPORT SURFACES 0 0 0 0 0 0 0 52.00 05200 OTHER ANGILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 61.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 0 0 0 61.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 61.00 07100 AMBULANCE 0 0 0 0 0 0 0 0 0 61.00 07100 AMBULANCE 0 0 0 0 0 0 0 0 0 61.00 07100 OTHER OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 61.00 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100 07100		i i	0	0		1		1
47.00 04700 CLECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0		1 1		0		1		
49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 540,370 0 540,370 0 0 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00		1 1	Ö	o		. 1		
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50. 00	48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	16, 720	o o	16, 720	48. 00
51.00 05100 SUPPORT SURFACES 0 0 0 66,317 0 66,317 51.00			1	0		1		
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0				0	•	1 1		
OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTER OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OUTPATLENT S								
60.00	32.00		<u> </u>	<u> </u>	,	<u> </u>		32.00
62.00	60.00	06000 CLI NI C	0	0	(0	0	60.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTERS O O O O O O O O O O O O O O O O O O			0	0	(이	0	1
OTHER REIMBURSABLE COST CENTERS O				0	(0	1
70. 00	03.00			<u> </u>		<u> </u>		03.00
72.00	70. 00		0	0	(0	0	70. 00
73. 00								
74.00 07400 07HER REIMBURSABLE COST 0 0 0 0 0 0 0 0 0			1	0		1 1		
SPECIAL PURPOSE COST CENTERS 80.00				0	•	1 1		
81. 00		SPECIAL PURPOSE COST CENTERS						
82. 00 08200 UTILIZATION REVIEW		1 1						
83. 00 08300 HOSPI CE 0 0 0 0 0 0 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 84. 00 89. 00 SUBTOTALS (sum of li nes 1-84) 0 390, 749 15, 526, 099 0 15, 526, 099 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0 0 90. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 3, 596 0 3, 596 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 95. 00 98. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 99. 00 99. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 99. 00								
84. 00		1 1	o	0	(ol ol	0	
NONRE MBURSABLE COST CENTERS		1 1	1	Ō	(
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 90. 00 91. 00 91.00 93. 596 0 3, 596 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 92. 00 93. 00 93. 00 93. 00 93. 00 93. 00 94. 00 94. 00 94. 00 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 95. 00 98. 00 0 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0	89. 00		0	390, 749	15, 526, 099	9 0	15, 526, 099	89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 0 3,596 0 3,596 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 0 93. 00 94. 00 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 95. 00 98. 00 0 0 0 0 0 0 98. 00 99. 00 Negati ve Cost Centers 0 0 0 0 0 0 99. 00	00.00			ما			0	00 00
92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 92. 00 93. 00 93.00 NONPAI D WORKERS 0 0 0 0 93. 00 94. 00 95. 00 0 0 0 0 0 0 94. 00 95. 00 0 0 0 0 0 0 95. 00 98. 00 0 0 0 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0				0		-		
94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 94.00 95.00 95.00 09500 0THER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 95.00 98.00 0 0 0 0 0 0 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 99.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	1	Ō	(
95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 99.00		l l	0	0	(이		
98.00 Cross Foot Adjustments		l l	0	0	(
99.00 Negative Cost Centers 0 0 0 0 99.00		1		0	(
100. 00 TOTAL 0 390, 749 15, 529, 695 0 15, 529, 695 100. 00				Ö	(0	99. 00
	100.0	D TOTAL	0	390, 749	15, 529, 695	5 0	15, 529, 695	100.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315364

				-	То	12/31/2021	Date/Time Pre 5/19/2022 1:1	
			CAPI TAL REL	ATED COSTS			37 177 2022 1. 1	7 piii
	Cost Center Description	Directly	BLDGS &	MOVABLE		Subtotal	EMPLOYEE	
	'	Assigned New	FIXTURES	EQUI PMENT			BENEFITS	
		Capi tal Rel ated Costs						
		0	1. 00	2.00		2A	3. 00	
1 00	GENERAL SERVICE COST CENTERS							1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT							1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0		o	0	0	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	281, 468		0	281, 468	0	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	175, 934 54, 277		0	175, 934 54, 277	0	6. 00
7. 00	00700 HOUSEKEEPI NG	O	17, 728		O	17, 728	0	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	0	289, 369 66, 931	1	0	289, 369 66, 931	0	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	00, 431		0	00, 431	0	10.00
11. 00	01100 PHARMACY	o	0		0	0	0	11. 00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	15, 801 24, 023		0	15, 801 24, 023	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	24, 023	1	0	24, 023	0	14. 00
15. 00	01500 ACTI VI TI ES	0	111, 315		0	111, 315	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	l ol	1, 568, 564		0	1, 568, 564	0	30. 00
31. 00	03100 NURSING FACILITY	0	1, 308, 304		0	1, 308, 304	0	31. 00
32. 00	03200 CF/IID	0	0		0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0		0	0	0	33. 00
40. 00	04000 RADI OLOGY	O	0		o	0	0	40. 00
41. 00	04100 LABORATORY	o	0	•	0	0	0	41. 00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		93, 202		0	93, 202	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	o	58, 002		o	58, 002	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	4, 368	1	0	4, 368	0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 10, 149		0	0 10, 149	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	o	73, 225		o	73, 225	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	0	51. 00 52. 00
02.00	OUTPATIENT SERVICE COST CENTERS							02.00
60.00	06000 CLINIC	0	0		0	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	'	0	0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		o	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS	1 0	0			ما	-	70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0	0	0	70. 00 71. 00
72. 00	07200 CORF	0	0		0	0	0	72. 00
73.00	07300 CMHC	0	0		0	0	0	73.00
74. 00	O7400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	l O	0		0	0	0	74. 00
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES				Т			80. 00
81. 00	08100 INTEREST EXPENSE							81. 00 82. 00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	0		0	0	0	82.00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	o	0		o	Ö	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	2, 844, 356		0	2, 844, 356	0	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	l ol	0		0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	Ō		0	Ö	0	91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	0	92.00
93. 00 94. 00	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY		0		0 0	O O	0	93. 00 94. 00
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS		0		Ő	o	0	95. 00
98. 00	Cross Foot Adjustments					О		98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	0	0 2, 844, 356		0	0 2, 844, 356	0	99. 00 100. 00
100.00	/ TOTAL	١	2,044,330	'	7	2, 044, 330	U	1.00.00

| Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315364

					0 12/31/2021	Date/Time Pre	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	5/19/2022 1: 1 DI ETARY	7 pm
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	281, 468 14, 528 7, 738 5, 340 27, 298 16, 502 1, 021 0 1, 253 5, 206	190, 462 4, 331 1, 415 23, 090 5, 341 0 0 1, 261 1, 917	66, 346 0 0 0 0 0 0 0	24, 483 3, 060 708 0 0 167 254	342, 817 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	6, 143	8, 882	0	1, 177	0	15. 00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	162, 518 0 0 0	125, 158 0 0 0	0 0	0	342, 817 0 0 0	30. 00 31. 00 32. 00 33. 00
40. 00	04000 RADI OLOGY	399	0	0	0	0	40. 00
41. 00 42. 00 43. 00 44. 00 45. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATIONAL THERAPY	678 821 915 8, 909 7, 828	0 0 0 7, 437 4, 628	1	-	0 0 0	41. 00 42. 00 43. 00 44. 00 45. 00
46.00	04600 SPEECH PATHOLOGY	3, 737	349	0	46	0	46. 00
47. 00 48. 00 49. 00 50. 00 51. 00 52. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVI CE COST CENTERS OUTPATI ENT SERVI CE COST CENTERS	0 217 9, 156 0 1, 196	0 810 5, 843 0 0	0	0 107 774 0 0	0 0 0 0 0	47. 00 48. 00 49. 00 50. 00 51. 00 52. 00
60.00	06000 CLI NI C	0	0	_	0	0	60. 00
61. 00 62. 00 63. 00	06100 RURAL HEALTH CLINIC 06200 FQHC 06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	61. 00 62. 00 63. 00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07200 CORF 07300 CMHC 07400 OTHER REIMBURSABLE COST	0 0 0 0	0 0 0 0	0	0	0 0 0 0	70. 00 71. 00 72. 00 73. 00 74. 00
00 00	SPECIAL PURPOSE COST CENTERS						00.00
80. 00 81. 00 82. 00 83. 00 84. 00 89. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 0 281, 403	0 0 190, 462	0 0 66, 346	0	0 0 342, 817	80. 00 81. 00 82. 00 83. 00 84. 00 89. 00
90. 00 91. 00 92. 00 93. 00 94. 00 95. 00 98. 00 99. 00 100. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	0 65 0 0 0 0 0 0 281, 468	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 66, 346	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 342, 817	90. 00 91. 00 92. 00 93. 00 94. 00 95. 00 98. 00 99. 00 100. 00

Provi der No.: 315364

					10 12/31/2021	5/19/2022 1:1	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	, p
		0.00	SUPPLY	11.00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	12.00	13. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
	1						ı
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6. 00 7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION	89, 482					9. 00
10. 00		07, 402	1, 021				10.00
11. 00	•		1, 021	(11. 00
12. 00	•		0		18, 482		12. 00
13. 00		o o	0	ì	0 10, 102	31, 400	13. 00
14. 00	1 · · · · · · · · · · · · · · · · · · ·		0	ì	0	01, 100	14. 00
15. 00	· •		0	ì	0	Ö	15. 00
10.00	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	`	<u> </u>		10.00
30. 00		89, 482	1, 021	(16, 256	31, 400	30.00
31. 00	•	0	0		0 0	0	31. 00
32. 00		o	0		o o	o o	32. 00
33. 00	•	0	0		0	0	33. 00
	ANCI LLARY SERVI CE COST CENTERS	· ·	-				
40.00		0	0	(29	0	40.00
41.00	04100 LABORATORY	0	0		65	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	(22	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(20	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	(681	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	(693	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	(367	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	48. 00
49. 00		0	0	(268	l e	49. 00
50. 00		0	0	(0	0	50. 00
51. 00	• • • • • • • • • • • • • • • • • • •	0	0	(81	0	51. 00
52. 00		0	0	[(0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00		0	0	(-	0	60.00
61. 00		0	U	(0	0	61.00
62. 00	1 · · · · · · · · · · · · · · · · · · ·		0				62.00
63. 00		0	0) 0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	O	0		ol o	0	70. 00
70.00	•		0	l			70.00
71.00		0	0			0	72.00
73. 00	•		0			Ö	73. 00
74. 00			0	ì	0	Ö	74. 00
, 00	SPECIAL PURPOSE COST CENTERS				<u>, </u>		,
80.00							80. 00
81. 00							81. 00
82. 00							82. 00
83. 00		0	0		0	0	83. 00
84. 00		0	0		0	0	84. 00
89. 00		89, 482	1, 021		18, 482	31, 400	89. 00
	NONREI MBURSABLE COST CENTERS			•			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	(0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	(0	0	92.00
93. 00		0	0	(0	0	93. 00
94. 00		0	0	(0	0	94. 00
95. 00		0	0	(0	0	95. 00
98. 00		0	0	(D		98. 00
99. 00		0	0		0	0	99. 00
100.0	0 TOTAL	89, 482	1, 021	l (18, 482	31, 400	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Cost Center Description						o 12/31/2021		
Cost Center Description				OTHER GENERAL			37 147 2022 1. 1	/ pill
ALLED HEALTH DIDICATION TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 00 TIS. 0		Cook Cooker December	NUDCI NO AND		0	D+ C+ D	T-+-1	
EDUCATION 15.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00		Cost Center Description		ACTIVITIES	Subtotai	•	lotai	
ERICRAL SERVICE COST CENTERS 1. 00 CO100 CAP REL COSTS - BLOSS A FIXTURES 2. 00 CO200 CAP REL COSTS - BLOSS A FIXTURES 3. 00 CO300 CAP REL COSTS - BLOSS A FIXTURES 3. 00 CO300 CAP RIL COSTS - BUNDABLE EQUIPMENT 3. 00 CO300 CAP RIL COSTS - BUNDABLE EQUIPMENT 3. 00 CO300 CAP RIL COSTS - BUNDABLE EQUIPMENT 3. 00 CO300 CAP RIL COSTS - BUNDABLE EQUIPMENT 3. 00 CO300 CAP RIL COSTS - BUNDABLE EQUIPMENT 4. 00 CO300 CABUN INSTRATIVE & GERRAL 5. 00 CO500 CABUN INSTRATIVE & GERRAL 5. 00 CO500 CABUN INSTRATIVE & GERRAL 7. 00 CO700 CO300 CABUN INSTRATIVE & GERRAL 8. 00 CO500 CABUN INSTRATIVE & GERRAL 8. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GERRAL 9. 00 CO500 CABUN INSTRATIVE & GE			EDUCATI ON			,		
1.00		CENEDAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
2.00	1 00							1 00
4. 00 00400 ADMINISTRATIVE & GENERAL								1
5.00 00500 PLANT OPERATION, MINIT & REPAIRS 6.00 6.00 00600 CAUNIDRY & LINEN SERVICE 6.00 6.00 00700 HOUSKEEPING 7.00 8.00 00800 DETARY								1
0.0000 LAINDRY & LINEN SERVICE								1
B. 00 00000 DIETARY								1
9.00 0.000 NURSING ADMINISTRATION 11.00 110.00 01000 CENTRAL SERVICES & SUPPLY 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 10.10 01300 SOCIAL SERVICE 11.00 15.00 01500 ADMINISTRA ADMINISTRATION 10.15.00 01500 ADMINISTRA ADMINISTRATION 10.15.00 01500 ADMINISTRA ADMINISTRATION 10.15.00 01500 ADMINISTRA ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMINISTRATION ADMI								1
10.00 01000 CANTRAL SERVI CES & SUPPLY								1
11. 00 01100 PHARMACY					•			1
13. 00 01300 SOCIAL SERVICE 13. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 1		01100 PHARMACY						1
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 127, 517 15. 00 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500 1500								1
15.00 01500 ACTIVITIES 0 127, 517 127, 517			0					1
0.0 0.0000 SXILLED NURSING FACILITY			0	127, 517				1
11 00 03100 NURSI NG FACILITY 0 0 0 0 0 0 0 31.00								
32.00 03300 OTHER LONG TERM CARE 0 0 0 0 32.00			0		1			1
33.00			0	•				1
40. 00 04000 RADIOLOGY 0 0 0 428 0 428 40. 00 420 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 42. 00 04. 00 04. 00 42. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 04. 00 0			0	•				1
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45. 00 04500 OCCUPATI ONAL THERAPY 0 0 71, 764 45. 00 46. 00 04600 SPECH PATHOLOGY 0 0 0 8, 867 0 8, 867 46. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		04300 OXYGEN (INHALATION) THERAPY	0	0	1			1
46. 00 04600 SPEECH PATHOLOGY 0 0 8,867 0 8,867 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0			0	0	1			1
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50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 50.00			0	0	1			1
51.00 05100 SUPPORT SURFACES 0 0 0 1,277 0 1,277 51.00			0	0	1			1
52. 00 05200 OTHER ANCI LLARY SERVI CE COST CENTERS O O O O O O O O O							-	1
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Heal th Financial Systems

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315364
Period:
From 01/01/2021
To 12/31/2021
Pate/Time Prepared:
5/19/2022 1:17 pm

Cast Center Description						1	o 12/31/2021	Date/Time Pre 5/19/2022 1:1	
STATISES SQUART TETT) SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQUART TETT SQ				CAPITAL REI	ATED COSTS			, 0, 1,,, 2,022	, p
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74. 00 07400 07HER REIMBURSABLE COST 0 0 0 0 0 0 74. 00		07200	CORF	Ö	Ö	C	Ö	0	72. 00
SPECIAL PURPOSE COST CENTERS 80. 00 00 00 00 00 00 00		1		0	0			l	
80. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 81. 00 82. 00 83. 00 83. 00 83. 00 83. 00 84. 00 84. 00 85. 00 85. 00 86. 00 86. 00 87. 00 88. 00 88. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80	74.00			0	0) 0	0	74.00
82.00 82.00 08200 UTILIZATION REVIEW		08000	MALPRACTICE PREMIUMS & PAID LOSSES						
83. 00 84. 00 84. 00 84. 00 0 0 0 0 0 0 0 0 0									
SUBTOTALS (sum of lines 1-84) 44,282 44,282 6,211,958 -2,389,215 13,137,437 89.00		08300	HOSPI CE	0	О	c	0	0	
NONREI MBURSABLE COST CENTERS O O O O O O O O O		08400		0	0	· ·			1
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 3,043 91. 00 92. 00 09200 PHYSI CIANS PRIVATE OFFICES 0 0 0 0 0 0 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 00 98. 00 99. 00 Cross Foot Adjustments Negative Cost Centers 0 0 0 0 95. 00 99. 00 Cost to be allocated (per Wkst. B, Part I) 0 0 0 0 1, 109, 158 103. 00 Unit cost multiplier (Wkst. B, Part I) 0 0 0 0 0 178552 105. 00 Unit cost multiplier (Wkst. B, Part I) 0 0 0 0 0 0 0 105. 00 Unit cost multiplier (Wkst. B, Part II) 0 0 0 0 0 0 0 105. 00 Unit cost multiplier (Wkst. B, Part II) 0 0 0 0 0 0 105. 00 Unit cost multiplier (Wkst. B, Part II) 0 0 0 0 0 0 0 105. 00 Unit cost multiplier (Wkst. B, Part II) 0 0 0 0 0 0 10 0 0 0 0 0 0 0 0 0	89. 00	NONRE	MRURSABLE COST CENTERS	44, 282	44, 282	6, 211, 958	-2, 389, 215	13, 137, 437	89.00
92. 00	90. 00			0	0	C	0	0	90. 00
93.00 09300 09300 NONPAID WORKERS 0 0 0 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 0 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 95.00 98.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0			l	
94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 95.00 98.00 99.00 Negative Cost Centers 0 0 0 0 0 99.00 00 0 0 0 0 0 0 0 0									
98.00 99.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Cross Foot Adjustments Negative Cost Centers 2, 844, 356 0 1, 109, 158 2, 389, 215 102.00 99.00 1, 109, 158 2, 389, 215 102.00 0 0. 178552 0 0. 181821 103.00 281, 468 104.00 281, 468 104.00 0 0. 000000 0 0. 021420 105.00	94.00	09400	PATIENTS LAUNDRY	0	0	c	0	0	94. 00
99. 00 Negative Cost Centers 2,844,356 0 1,109,158 2,389,215 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 64.232781 0.000000 0.178552 0.181821 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 0.000000 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 105.00 Unit cost multiplier (Wkst. B, Part III) 0.000000 0.000000 105.00 Unit cost multiplier (Wkst. B, Part IIII) 0.0000000 0.0000000 105.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		09500		0	0	C	0	0	1
102.00 Cost to be allocated (per Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part I) Cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Cost multiplier (Wkst. B, Part II) Cost m									
103.00 Unit cost multiplier (Wkst. B, Part I) 64.232781 0.000000 0.178552 0.181821 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 0.000000 0.000000 0.000000 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 0.001420 105.00	102.00)		2, 844, 356	0	1, 109, 158	3	2, 389, 215	102. 00
104.00 Cost to be allocated (per Wkst. B, Part II) 0 281,468 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.021420 105.00	103. 00			64. 232781	0. 000000	0. 178552	,	0. 181821	103, 00
105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.021420 105.00			Cost to be allocated (per Wkst. B,	5 202701	3. 333330	0.170032		l e	1
	105 00		,			0.00000		0 021420	105.00
	100.00	ή				0.000000		0.021420	103.00

Provi der No.: 315364

				1	0 12/31/2021	Date/lime Pre 5/19/2022 1:1	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, p
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(TOTAL PATIENT			CTOTAL DATIENT	
		(SQUARE FEET)	DAYS)			(TOTAL PATIENT DAYS)	
		5. 00	6.00	7. 00	8. 00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL			•			3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	37, 161					5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	845	1				6. 00
7. 00	00700 HOUSEKEEPI NG	276	1	36, 040			7. 00
8.00	00800 DI ETARY	4, 505	0	4, 505			8. 00
9.00	00900 NURSING ADMINISTRATION	1, 042	. 0	1, 042	0	48, 518	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0		0	_	0	10. 00
11.00	01100 PHARMACY	0		0	_	0	11. 00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	246 374		246 374		0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	3/4		3/4	0	0	14. 00
15. 00	01500 ACTIVITIES	1, 733		1, 733	0	0	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,700		1,700			10.00
30.00	03000 SKILLED NURSING FACILITY	24, 420	48, 518	24, 420	145, 554	48, 518	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	1	0	0	_	32. 00
33. 00	03300 OTHER LONG TERM CARE	0) 0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		1		0	0	40. 00
41. 00	04100 LABORATORY	1 0			0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY		o o	Ö	0	Ö	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	O	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	1, 451	0	1, 451	0	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	903	0	903		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	68	l .	68	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	150	1	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	158 1, 140	l .	158 1, 140	0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	1, 140	l .	1, 140	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0		Ö	0	0	51. 00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS	_	_	_	I		
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FOHC		,		0	0	62. 00
63. 00		0	0	o	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	1	70. 00
71. 00	1	0	0	0	0	0	71. 00
	07200 CORF 07300 CMHC			0	0	0	72. 00 73. 00
	07400 OTHER REIMBURSABLE COST	1 0			0	0	74.00
7 1. 00	SPECIAL PURPOSE COST CENTERS		,				71.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW						82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST CENTERS	0			0	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	37, 161	48, 518	36, 040	145, 554		89. 00
07.00	NONREI MBURSABLE COST CENTERS	37, 101	40,510	30,040	140, 334	40, 510	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS				0	0	94. 00 95. 00
98. 00	Cross Foot Adjustments		,		0	0	98. 00
99. 00							99. 00
102.00		801, 580	445, 178	300, 569	1, 640, 871	941, 631	
	Part I)	1					
103.00		21. 570464	1	1			
104.00	Cost to be allocated (per Wkst. B, Part II)	190, 462	66, 346	24, 483	342, 817	89, 482	104.00
105.00		5. 125320	1. 367451	0. 679329	2. 355256	1. 844305	105. 00
23.30	II)						

	Financial Systems	JERSEY SHUR				u or Form CWS	2340-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	5/19/2022 1:1 NURSI NG AND	7 pm
	555t 55to. 5555t pt. 5	SERVICES &	(COSTED	RECORDS &	0001712 021111 02	ALLI ED HEALTH	
		SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT DAYS)	EDUCATION	
		(COSTED REQUIS.)		(GROSS CHARGES)	DAYS)	(ASSI GNED TIME)	
		10.00	11. 00	12.00	13. 00	14. 00	
4 00	GENERAL SERVICE COST CENTERS	1					1 00
1. 00 2. 00	OO100 CAP REL COSTS - BLDGS & FLXTURES OO200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	70.004					9.00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	78, 994 0	0				10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	o o	0	27, 596, 785	5		12. 00
13.00	01300 SOCI AL SERVI CE	0	0	C	48, 518		13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	0			0	14. 00 15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0		,	0	15.00
30. 00	03000 SKILLED NURSING FACILITY	78, 994	0	24, 274, 197	48, 518	0	
	03100 NURSING FACILITY	0	0	C	0	0	
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0			0	32. 00 33. 00
00.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			, <u> </u>		00.00
40. 00	04000 RADI OLOGY	0	0	42, 542		0	
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	97, 290 32, 116		0	41. 00 42. 00
	04300 OXYGEN (INHALATION) THERAPY		0	29, 363		0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	1, 016, 839		0	44. 00
	04500 OCCUPATI ONAL THERAPY	0	0	1, 035, 040		0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY		0	548, 318	1	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	0	Č	o o	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	399, 547	o o	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	101 500	0	0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS		0	121, 533 C		0	ł
	OUTPATIENT SERVICE COST CENTERS	-					
60.00	06000 CLINIC	0	0			0	
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		,	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	С	0	0	ı
70.00	OTHER REIMBURSABLE COST CENTERS				ا	0	70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0	0	70. 00 71. 00
	07200 CORF	l o	0	Č	o o	0	1
73. 00	07300 CMHC	0	0	C	-	0	
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0	C) 0	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81. 00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW		0	,		0	82.00
84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST CENTERS		0			0	
89. 00	SUBTOTALS (sum of lines 1-84)	78, 994	0	27, 596, 785	48, 518	0	1
	NONREI MBURSABLE COST CENTERS			Г			
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	·		0	
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0		o o	0	92.00
	09300 NONPALD WORKERS	0	0	c	o	0	
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	
98. 00	Cross Foot Adjustments		Ü			O	98.00
99. 00	Negative Cost Centers						99. 00
102.00		56, 347	0	76, 513	298, 423	0	102. 00
103. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 713307	0. 000000	0. 002773	6. 150769	0. 000000	103 00
103.00		1, 021	0.00000	18, 482			104. 00
	Part II)						
105. 00	Unit cost multiplier (Wkst. B, Part	0. 012925	0. 000000	0. 000670	0. 647182	0. 000000	105. 00
	1 1117	ı		1	1	ı	ı

JERSEY SHORE CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | | To | 12/31/2021 | Date/Time Prepared: | Provi der No.: 315364

			To 12,	/31/2021 Date/Time Prepared: 5/19/2022 1:17 pm
		OTHER GENERAL		
	Coot Conton Decemintion	SERVI CE		
	Cost Center Description	ACTIVITIES (TOTAL PATIENT		
		DAYS)		
	OFNEDAL CEDIU OF COCT OFNEDO	15. 00		
1. 00	GENERAL SERVICE COST CENTERS 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 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE			5. 00 6. 00
7. 00	00700 HOUSEKEEPING			7. 00
8. 00	00800 DI ETARY			8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY			9.00
11. 00	01100 PHARMACY			10. 00 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 01500 ACTIVITIES	48, 518		14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	40, 510		15.00
30. 00	03000 SKILLED NURSING FACILITY	48, 518		30.00
31. 00	03100 NURSING FACILITY	0		31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0		32. 00 33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		33. 00
40. 00	04000 RADI OLOGY	0		40. 00
41.00	04100 LABORATORY	0		41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY			42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	o o		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0		46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o		48.00
49. 00	04900 DRUGS CHARGED TO PATIENTS	O		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0		51. 00 52. 00
02.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		32. 00
60.00	06000 CLI NI C	0		60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0		61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	О		63. 00
	OTHER REIMBURSABLE COST CENTERS			
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0		70. 00 71. 00
71.00				72.00
	07300 CMHC	O		73. 00
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0		74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00	08100 INTEREST EXPENSE			81. 00
82.00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE			82.00
83. 00 84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0		83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	48, 518		89. 00
	NONREI MBURSABLE COST CENTERS	T al		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0		90.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	o		92.00
93. 00	09300 NONPALD WORKERS	O		93. 00
94. 00 95. 00	09400 PATIENTS LAUNDRY	0		94. 00 95. 00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments			95.00
99. 00	Negative Cost Centers			99. 00
102.00	71	390, 749		102. 00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	8. 053691		103.00
103.00		127, 517		104. 00
	Part II)			
105.00	Unit cost multiplier (Wkst. B, Part	2. 628241		105. 00
	1 17	1		I

Health Financial Systems	JERSEY SHORE C	ENTER	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES	FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der No.: 315364 Peri od	d: Worksheet C

Health Fina	incial Systems	JERSEY SHORE CE	NIER		In Lie	u of Form CMS-2	2540-10
RATIO OF CO	OST TO CHARGES FOR ANCILLARY AND OUTPATIENT	COST CENTERS	Provi der	No.: 315364	Peri od:	Worksheet C	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pre	
	Cost Center Description			Total (from	Total Charges	5/19/2022 1:1 Ratio (col. 1	/ pili
	cost center bescriptron			Wkst. B. Pt I		di vi ded by	
				col. 18)	1	col. 2	
				1.00	2. 00	3, 00	
ANCI	LLARY SERVICE COST CENTERS			1.00	2.00	3.00	
	O RADI OLOGY			22, 14	17 42, 542	0. 520591	40. 00
	O LABORATORY			37, 69	•		41.00
	O I NTRAVENOUS THERAPY			45, 39			
	O OXYGEN (INHALATION) THERAPY					1. 722133	
	O PHYSI CAL THERAPY			50, 50			
				537, 76			
	O OCCUPATI ONAL THERAPY			461, 7			
	O SPEECH PATHOLOGY			209, 72	548, 318		
	O ELECTROCARDI OLOGY				0	0. 000000	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS			16, 72		0. 000000	
	O DRUGS CHARGED TO PATIENTS			540, 37	399, 547	1. 352457	49. 00
	O DENTAL CARE - TITLE XIX ONLY				0	0. 000000	
	O SUPPORT SURFACES			66, 3°	121, 533	0. 545671	51. 00
	OOTHER ANCILLARY SERVICE COST CENTERS				0 0	0.000000	52. 00
	ATIENT SERVICE COST CENTERS				-		
60.00 0600	O CLI NI C				0	0.000000	60.00
61. 00 0610	O RURAL HEALTH CLINIC						61. 00
62. 00 0620	O FQHC						62. 00
63.00 0630	O OTHER OUTPATIENT SERVICE COST CENTER				0	0.000000	63.00
71. 00 0710	O AMBULANCE				0	0.000000	71. 00
100. 00	Total			1, 988, 48	3, 322, 588		100. 00

*		RE CENTER			u of Form CMS-2	
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	narod:
				10 12/31/2021	5/19/2022 1:1	pareu. 7 pm
		Title	XVIII (1)	Skilled Nursing	PPS	
			. ,	Facility		
		Health Care Pr	rogram Charges	Health Care	Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges (Fr. Wkst. C			x col. 2)	x col. 3)	
	Column 3)					
	1.00	2. 00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	TENT COST					1
0. 00 04000 RADI OLOGY	0. 520591	14, 349		0 7, 470	0	40.00
1. 00 04100 LABORATORY	0. 387491	3, 566		0 1, 382	0	
2. 00 04200 I NTRAVENOUS THERAPY	1. 413408			0 21, 279	0	
3.00 04300 OXYGEN (INHALATION) THERAPY	1. 722133			0 20, 571	0	
4. 00 04400 PHYSI CAL THERAPY	0. 528863	510, 771		0 270, 128	0	44.00
5. 00 04500 OCCUPATI ONAL THERAPY	0. 446139	532, 092		0 237, 387	0	45.00
6. 00 04600 SPEECH PATHOLOGY	0. 382495	332, 963		0 127, 357	0	46.00
7. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
8.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48. 00
9.00 04900 DRUGS CHARGED TO PATIENTS	1. 352457	170, 931		0 231, 177	0	49.00
0.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
11. 00 05100 SUPPORT SURFACES	0. 545671	161		0 88	0	51.00
2.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
0. 00 06000 CLI NI C	0. 000000	0		0 0	0	
1.00 06100 RURAL HEALTH CLINIC						61.00
2. 00 06200 FQHC						62.00
3.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	- 1		0 0	0	
1.00 07100 AMBULANCE (2)	0. 000000			0	0	
00.00 Total (Sum of lines 40 - 71)		1, 591, 833		0 916, 839	0	100.00
1) For title V and XIX use columns 1, 2, and 4 onl						

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

E, Part I, line 18 Total Cost From Wkst. B, Part I, Col. Cost Center Description From Wkst. B, Part I, Col. Cost (From Wkst. B, Part I, Col. Cost (From Wkst. B, Part I, Col. Cost to Total Costs For Pass Through (Col. 3 x Col. 4)	Heal th	Fi nan	cial Systems	JERSEY SHOF	RE CENTER		In Lie	u of Form CMS-	2540-10
PART - APPORTIONMENT OF VACCINE COST 1.00	APPORT	I ONMEN	IT OF ANCILLARY AND OUTPATIENT COSTS				From 01/01/2021	Parts II-III Date/Time Pre	
Cost Center Description					Ti tl	e XVIII		PPS	
PART II - APPORTIONMENT OF VACCINE COST			Cost Center Description				·	1 00	
1.00		PΔRT	II - APPORTIONMENT OF VACCINE COST					1.00	
2.00 Program vaccine charges (From your records, or the PS&R) 2,134 2.00 3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet 2,886 3.00 E, Part I, I line 18) Total Cost (From Wkst. B, Allied Health (From Wkst. B, Allied Health (From Wkst. B) Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, C		IAKI		st to charges	(From Workshee	t C column 3	line 49)	1 352457	1 00
3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet 2,886 3.00						c 0, 00. a	,		
E, Part I, line 18 Total Cost From Wkst. B, Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part I, Col. Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III Part III	3.00					er this amoun	t to Worksheet	-	
Cost (From Wkst. B, Part I, Col. 18 From Wkst. B, Part I, Col. 2 Cost (From Wkst. B, Part I, Col. 2)				,				,	
Part I, Col. (From Wkst. B, Part I, Col. Costs to Total Costs to Total Costs to Total Costs to Total Costs - Part A (Col. 2 / Col. 1) 1.00			Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
18			·	(From Wkst. B,	Allied Health	Nursing &	Cost (From	& Allied	
14) Costs - Part A (Col . 2 / Col . 1) Through (Col . 3 x Col . 4)				· ·					
ACCOUNT CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH ANCILLARY SERVICE COST CENTERS				18			, , , ,		
PART - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH					14)				
1.00 2.00 3.00 4.00 5.00						1		3 x Col. 4)	
ANCI LLARY SERVI CE COST CENTERS 40. 00				1.00	2.00	.,	4. 00	5. 00	
40. 00		PART	III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH	-			
41. 00		ANCI LI	LARY SERVICE COST CENTERS						
42. 00				22, 147	(0	
43. 00					(0	
44. 00		1			(
45. 00					(_	
46. 00					(_	
47. 00 0470 0 ELECTROCARDI OLOGY 0 0.000000 0 0 47. 00 48. 00 0480 0 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 16, 720 0 0.000000 0 0 48. 00 49. 00 0490 0 DRUGS CHARGED TO PATI ENTS 540, 370 0 0.000000 231, 177 0 49. 00 50. 00 0500 0 DENTAL CARE - TITLE XIX ONLY 0 0.000000 0 0 50. 00 51. 00 05100 SUPPORT SURFACES 66, 317 0 0.000000 88 0 51. 00 52. 00 05200 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 0 52. 00					(1	•	_	
48. 00		1		209, 729	(1	•	_	
49. 00 04900 DRUGS CHARGED TO PATIENTS 540,370 0 0.000000 231,177 0 49.00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 0 0.000000 0 50.00 51. 00 05100 SUPPORT SURFACES 66,317 0 0.000000 88 0 51.00 52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0.000000 0 0.000000				0	(_	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 0 50.00 51.00 51.00 05100 SUPPORT SURFACES 66,317 0 0.000000 88 0 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0.000000 0 52.00					(1			
51. 00 05100 SUPPORT SURFACES 66, 317 0 0.000000 88 0 51. 00 52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0.000000 0 52. 00				540, 370	(_	
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0 52.00		1		(/ 217					
		1		66, 317					
	100.00		Total (Sum of Lines 40 - 52)	1, 988, 483		1	916, 839		

ealth Fina	ncial Systems	JERSEY SHORE C	ENTER	In Lie	u of Form CMS-2	2540-1
COMPUTATI ON	OF INPATIENT ROUTINE COSTS		Provi der No.: 315364	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/19/2022 1:1	pared:
			Title XVIII	Skilled Nursing Facility		
					1. 00	
PART	I CALCULATION OF INPATIENT ROUTINE	COSTS			1.00	
I NPA	FLENT DAYS					1
. 00 I npa	tient days including private room d	ys			48, 518	1.0
	ate room days				218	1
	tient days including private room d				6, 227	1
	cally necessary private room days a		n		0	
	I general inpatient routine service ATE ROOM DIFFERENTIAL ADJUSTMENT	COST			13, 537, 616	5.0
	ral inpatient routine service charg	ie.			23, 423, 608	6.0
	ral inpatient routine service charg		vided by line 6)		0. 577948	
						8.0
						9. 0
2)	2)					
.00 Enter semi-private room charges from your records					23, 280, 600 482, 00	
	I.OO Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)					11.0
	age per diem private room charge di	ferential (Line 9 minus	s line 11)		174.00	12.0
3.00 Aver	age per diem private room cost diffe	rential (Line 7 times I	ine 12)		100. 56	13.0
4.00 Priv	ate room cost differential adjustme	t (Line 2 times line 1	3)		21, 922	14. (
	ral inpatient routine service cost	et of private room cos	t differential (Line 5	minus line 14)	13, 515, 694	15. 0
	RAM INPATIENT ROUTINE SERVICE COSTS sted general inpatient service cost	nor diam (line 15 divi	dad by Line 1)		278. 57	l 16. (
	ram routine service cost (Line 3 t		ded by TTNe T)		1, 734, 655	
	cally necessary private room cost a		ine 4 times line 13)		1, 734, 033	1
	I program general inpatient routine		,		1, 734, 655	
	tal related cost allocated to inpat			t II column 18,	2, 547, 670	20.0
line	30 for SNF; line 31 for NF, or line	32 for ICF/IID)				
1	diem capital related costs (Line 2	3			52. 51	1
	ram capital related cost (Line 3 t				326, 980	
	tient routine service cost (Line 1		.:		1, 407, 675	
	egate charges to beneficiaries for			1: 24)	0	1
	I program routine service costs for r the per diem limitation (1)	comparison to the cost	ilmitation (Line 23 mi	nus iine 24)	1, 407, 675	25. 26.
	tient routine service cost limitation	n (line 3 times the new	diem limitation line	26) (1)		27.
	bursable inpatient routine service					28.
	nsfer to Worksheet E, Part II, line					
, ,	6 and 27 are not applicable for tit	, ,	ed for title V and or t	title XIX	•	

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	48, 518	1. 00
2.00	Program inpatient days (see instructions)	6, 227	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. 128344	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Н	ealth Financial Systems		JERSEY SHORE CE	NTER	In Lie	u of Form CMS-2540-10
C	ALCULATION OF REIMBURSEMENT	SETTLEMENT FOR TITLE XVIII		Provi der No.: 315364	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 5/19/2022 1:17 pm
				Title XVIII	Skilled Nursing	PPS

				3/19/2022 1.1	7 pili
		Title XVIII	Skilled Nursing Facility	PPS	
				1	
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1. 00	Inpatient PPS amount (See Instructions)			4, 245, 474	
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0 4, 245, 474	
3.00					
4.00	Primary payor amounts			0 489, 372	4. 00
5.00	Coi nsurance				5. 00
6.00	Allowable bad debts (From your records)			134, 483	
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ıcti ons)		112, 563	
8.00	Adjusted reimbursable bad debts. (See instructions)			87, 414	
9.00	Recovery of bad debts - for statistical records only			0	
10. 00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			3, 843, 516	
12. 00	Interim payments (See instructions)			3, 823, 225	
13.00	Tentati ve adjustment			0	
14. 00	OTHER adjustment (See instructions)			0	
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			6, 286	
14. 75	Sequestration for non-claims based amounts (see instructions)			0	
14. 99	Sequestration amount (see instructions)			0	14. 99
15. 00	Balance due provider/program (see Instructions)			14, 005	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			2, 886	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			2, 886	
20.00	Medicare Part B ancillary charges (See instructions)			2, 134	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			2, 134	
22. 00	Primary payor amounts			0	
23. 00	Coinsurance and deductibles			0	23. 00
24.00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	icti ons)		0	
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)			2, 134	
26. 00	Interim payments (See instructions)			2, 134 0	
27. 00	Tentati ve adjustment				27. 00
28. 00	Other Adjustments (See instructions) Specify			0	
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55 28. 99	Demonstration payment adjustment amount after sequestration				28. 55 28. 99
	Sequestration amount (see instructions)			0	
29. 00	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 15 2	soction 115 2	0	29. 00 30. 00
30.00	Triotested amounts (Notial rowable cost report itells) III accordance	e with two rub. 15-2,	35611011 113. 2	U	30.00

Health Financial Systems	JERSEY SHORE CE	ENTER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEM	ENT TITLE V and TITLE XIX ONLY	Provider No.: 315364	From 01/01/2021	Worksheet E Part II Date/Time Prepared: 5/19/2022 1:17 pm
		Title XIX	Skilled Nursing	PPS

		TI LIE XIX	Facility	113	
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES			1.00	
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	3)		0	3.00
4. 00	Inpatient routine services (see instructions)			0	4.00
5. 00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6. 00	Cost of covered services (Sum of Lines 1 - 5)	01 (3)		0	6.00
7. 00	Differential in charges between semiprivate accommodations and	less than seminrivate ac	commodations	0	7. 00
8. 00	SUBTOTAL (Line 6 minus line 7)	1 c33 than 3cm pri vate ac	Commoda ti oris	0	8.00
9. 00	Primary payor amounts			0	9. 00
10. 00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00
10.00	REASONABLE CHARGES			0	10.00
11. 00	Inpatient ancillary service charges			0	11. 00
12. 00	Outpatient service charges			0	12.00
	Inpatient routine service charges			0	13. 00
	Differential in charges between semiprivate accommodations and	less than seminrivate ac	commodations	0	14.00
	Total reasonable charges	ress than semi private ac	.commoda ti oris	0	15. 00
13.00	CUSTOMARY CHARGES			0	13.00
16. 00	Aggregate amount actually collected from patients liable for pa	vment for services on a	charge hasis	0	16. 00
17. 00	Amounts that would have been realized from patients liable for			0	17. 00
17.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services on	a charge basis	J	17.00
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.000000	18. 00
19. 00	· · · · · · · · · · · · · · · · · · ·			0	19.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)			0	20.00
21. 00	Deducti bl es			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
	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 erroneousl	y collected based on cor	rection of	0	27. 00
	cost limit				
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in pr	ogram	0	28. 00
29. 00	utilization Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depred	iable assets (0	30.00
	if minus, enter amount in parentheses)				
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 parenthe	ses) (see	0	33. 00
	Instructions)				

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED PROVIDERS FOR SERVICES RENDERED PROVIDER NO.: 315364 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/19/2022 1:17 pm

Title XVIII Skilled Nursing PPS

Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 2.00 3.828,830 2.134 1.00 2.00 3.828,830 2.134 1.00 2.00 3.828,830 2.134 1.00 2.00 3.828,830 2.134 1.00 2.00 3.828,830 2.134 1.00 2.00 3.828,830 2.134 1.00 2.00 3.828,830 2.134 1.00 2.00 3.828,830 2.134 1.00 3.828,830 2.134 1.00 3.828,830 2.134 1.00 3.828,830 2.134 1.00 3.828,830 2.134 1.00 3.828,830 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00			11 11	e XVIII S	killed Nursing	PPS	
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TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 0 5.02 5.03 0 0 0 5.02 5.03 0 0 0 0 5.02 5.03 0 0 0 0 5.50 5.03 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 0 0 0 5.50 5.03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
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5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 - 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 14,005 0 6.01 6.02 PROVIDER TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 3,837,230 2,134 7.00	5. 51			0		0	5. 51
- 5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)	5.52			0		l ol	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1.00 2.00	5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
the cost report. (1) PROGRAM TO PROVIDER 6.01 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) 14,005 0 0 6.01 0 6.02 3,837,230 Contractor Name Contractor Number 1.00 2.00		- 5. 98)					
6.01 PROGRAM TO PROVIDER 0 14,005 0 6.01 PROVIDER TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 3,837,230 2,134 7.00 Contractor Name Contractor Number 1.00 2.00	6.00						6.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 3,837,230 2,134 7.00 Contractor Name Contractor Number 1.00 2.00	6. 01						
Contractor Name Contractor Number 1.00 2.00	6. 02			_			
Number 1.00 2.00	7. 00	Total Medicare program liability (see instructions)					7. 00
1.00 2.00				Contract	or Name		
V ()() INamo of Contractor		lu a a company		1.	00	2.00	
6.00 Name of Contractor		Name of Contractor					8. 00

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

Health Financial Systems

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

| Period: | Worksheet G | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/19/2022 1:17 pm

oni y)					5/19/2022 1:1	7 pm
		General Fund	Specific E Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					4
1. 00	Cash on hand and in banks	-34, 615	0	0	0	1.0
2.00	Temporary investments	0	0	0	0	2.0
3.00	Notes receivable	0	0	0	0	
4. 00	Accounts recei vable	2, 543, 177	0	0	0	
5.00	Other receivables	14, 528		0	0	
6. 00	Less: allowances for uncollectible notes and accounts receivable	-606, 605	0	U	0	6.0
7. 00	Inventory	68, 661	0	0	0	7.0
8. 00	Prepaid expenses	00,001	l o	o	0	
9. 00	Other current assets	0	О	0	0	9.0
10. 00	Due from other funds	0	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 985, 146	0	0	0	11. C
40.00	FI XED ASSETS	1 0	I	٥		1 40 0
12.00	Land	0	0	0	0	
13. 00 14. 00	Land improvements Less: Accumulated depreciation	0	0	0	0	
15. 00	Buildings		0	0	0	1
16. 00	Less Accumulated depreciation	0	0	0	0	
17. 00	Leasehold improvements	545, 619	l o	o	0	
18. 00	Less: Accumulated Amortization	-119, 918		o	0	
19. 00	Fi xed equipment	136, 895	0	0	0	19.0
20. 00	Less: Accumulated depreciation	-77, 715	0	0	0	20.0
21. 00	Automobiles and trucks	0	0	0	0	21.0
22. 00	Less: Accumulated depreciation	0	0	0	0	1
23. 00	Major movable equipment	902, 305		0	0	
24. 00	Less: Accumulated depreciation	-703, 553	0	0	0	1
25. 00	Mi nor equipment - Depreciable	0	0	0	0	
26.00	Mi nor equipment nondepreciable	0	0	O O	0	1
27. 00 28. 00	Other fixed assets	683, 633	0	U O	0	
26. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	003,033	<u>U</u>	<u>U</u>	0	J 20. C
29. 00	Investments	0	0	ol	0	29.0
30.00	Deposits on Leases	l o	l o	o	0	
31. 00	Due from owners/officers	-2, 785, 986	0	0	0	
32. 00	Other assets	14, 715, 757	O	0	0	32.0
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	11, 929, 771	0	0	0	33.0
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	14, 598, 550	0	0	0	34. C
	Liabilities and Fund Balances					
35. 00	CURRENT LIABILITIES	964, 714	0	ol	0	35. C
36. 00	Accounts payable Salaries, wages, and fees payable	904, 714	0	0	0	
37. 00	Payroll taxes payable		0	0	0	1
38. 00	Notes & Loans payable (Short term)	0	0	0	0	
39. 00	Deferred income	l o	l o	o	0	
40. 00	Accel erated payments	0				40. C
41. 00	Due to other funds	-86, 960	0	0	0	41.0
42. 00	Other current liabilities	1, 069, 924	0	0	0	42. C
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 947, 678	0	0	0	43. C
	LONG TERM LIABILITIES	1				4
44. 00	Mortgage payable	15, 442, 716		0	0	
45. 00	Notes payable	0	0	0	0	
46. 00	Unsecured Loans	0	0	0	0	
47. 00 48. 00	Loans from owners: Other long term liabilities	0	0	U O	0	
49. 00	APIC DISTRIBUTIONS; R/E EARNINGS	-2, 319, 078	0	0	0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	13, 123, 638		0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	15, 071, 316		o	0	
	CAPITAL ACCOUNTS			-1		
52. 00	General fund balance	-472, 766				52. 0
53. 00	Specific purpose fund		0			53.0
54. 00	Donor created - endowment fund balance - restricted			0		54. (
55. 00	Donor created - endowment fund balance - unrestricted			0		55. (
56.00	Governing body created - endowment fund balance			0	~	56. (
57. 00 58. 00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 0
50. 00	LIED ALEBETT AND EXDANSION	1	1			1
		_ 172 766	ا ما	ΛI	^	1 50 0
59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-472, 766 14, 598, 550		0	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES JERSEY SHORE CENTER In Lieu of Form CMS-2540-10

Provi der No.: 315364 | Peri od: | Worksheet G-1 | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

					То	12/31/2021	Date/Time Pre 5/19/2022 1:1	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	·
		1.00	2.00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0 0 0 0 0	0 -472, 766 -472, 766 -472, 766 0 -472, 766		0 0 0 0	0	0 0 0 0 0 0	9. 00 10. 00 11. 00 12. 00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0 0	0 -472, 766		0 0 0 0	0	1	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0	0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0	0 0 0 0		0 0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315364	Per From To	iod: m 01/01/2021 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/19/2022 1:1	pared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						4
1. 00	SKILLED NURSING FACILITY		24, 274, 1	97		24, 274, 197	
2. 00	NURSING FACILITY			0		0	
3. 00	ICF/IID			0		0	
4. 00	OTHER LONG TERM CARE			0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		24, 274, 1	97		24, 274, 197	5.00
	All Other Care Services						
6. 00	ANCI LLARY SERVI CES		3, 333, 0	06	0	3, 333, 006	6.0
7. 00	CLINIC				0	0	7.0
8. 00	HOME HEALTH AGENCY COST				0	0	8.00
9. 00	AMBULANCE				0	0	9. 0
10.00	RURAL HEALTH CLINIC				0	0	10.0
10. 10	FOHC				0	0	10. 10
11. 00	CMHC				0	0	11.00
11. 10	CORF				0	0	11. 10
12. 00	HOSPI CE			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	3 to	27, 607, 2	03	0	27, 607, 203	14.00
	Worksheet G-3, Line 1)						
	Cost Center Description						
					1. 00	2. 00	
	PART II - OPERATING EXPENSES					1/ 000 017	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					16, 880, 917	1.0
2.00	Add (Specify)				0		2. 0
3. 00					O		3.0
4. 00					0		4. 0
5.00					0		5.0
6. 00					0		6.0
7. 00					o	_	7.0
3.00	Total Additions (Sum of lines 2 - 7)					0	
9.00	Deduct (Specify)				0		9.0
10.00					0		10.0
11. 00					이		11.0
12. 00					이		12. 0
13.00					0		13.0
	T-+-! D!+! (C6 !! 0 12)						1 1 1 0

0 14.00

16, 880, 917 15. 00

14.00 Total Deductions (Sum of lines 9 - 13)
15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

Health Financial Systems JERSEY SHORE CENTER		ORE CENTER	In Lieu of Form CMS-2540-10		
STATE	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315364	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/19/2022 1:17 pm	
				1. 00	
1.00	00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			27, 607, 203	1.00
2.00	Less: contractual allowances and discounts on patients accounts			11, 222, 655	2.00
3.00	Net patient revenues (Line 1 minus line 2)			16, 384, 548	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)			16, 880, 917	4.00
5.00	Net income from service to patients (Line 3 minus 4)			-496, 369	5. 00
Other income:					