Heal th Financia		APLE GLEN CEN			u of Form CMS-2540-10			
	required by law (42 USC 1395g; 42 CFR 413.2 since the beginning of the cost reporting po				FORM APPROVED OMB NO. 0938-0463			
		<u> </u>			Expires: 12/31/2021			
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315328 Period: From 01/01/2 To 12/31/2 PART I - COST REPORT STATUS PART I - COST REPORT STATUS Provider CCN: 315328								
PART I - COST F	REPORT STATUS							
Provi der	 [X] Electronically prepared cost rep 	Date: 5/17/20	23 Time: 2:38 pm					
use only	2. [] Manually prepared cost report							
	3. [0] If this is an amended report ent	ter the number	r of times the provide	r resubmitted thi	s cost report			
	3.01 [] No Medicare Utilization. Enter "	'Y" for yes or	r leave blank for no.					
Contractor	4.[1]Cost Report Status	6. Contractor	No.					
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN				
	Settled without audit	8.[N] Last	Cost Report for this	Provider CCN				
	(3) Settled with audit	9. NPR Date:	·					
	(4) Reopened	10.[0] f] i	ine 4, column 1 is "4"	Enter number of	times reopened			
	(5) Amended		r Vendor Code					
	5. Date Received:		care Utilization. Ente no utilization.	er "F" for full, '	'L" for low, or "N"			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OF 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 MAPLE GLEN CENTER (315328) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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	Diane Morris		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	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	-24, 013	3, 552	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	-24, 013	3, 552	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.

Heal th	Financial Systems	MAPL	.E GLEN CENT	ER		1	n Lie	u of For	m CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI					Period:		Workshe		
COMPLE	X INDENTIFICATION DATA					From 01/01/		Part I		
						To 12/31/	2022	Date/Ti 5/17/20		
	1.00	2	. 00		3.00			0/11/20	20 2.0	
	Skilled Nursing Facility and Skilled Nursing	Facility	Complex Ad	dress:						
	Street: 12-15 SADDLE RIVER ROAD	PO Box:								1.00
	City: FAIR LAWN	State: N.		Zip Code						2.00
	County: BERGEN	CBSA Code		Urban/Ru	ral:U					3.00
3.01		CBSA Code		and Nama	Duran di ala m	D-+-	Dation		(D	3.01
			Compon	ent Name	Provi der CCN	Date Certified	Paym	ent Syst O, or N		
					CON	certifieu	v		, XI X	-
			1	. 00	2.00	3.00	4.00		6.00	
	SNF and SNF-Based Component Identification:									
4.00	SNF		MAPLE GLEN	CENTER	315328	07/01/1976	N	Р	Р	4.00
	Nursing Facility									5.00
	ICF/IID									6.00
	SNF-Based HHA									7.00
	SNF-Based RHC									8.00
	SNF-Based FQHC SNF-Based CMHC									9.00 10.00
	SNF-Based OLTC									11.00
	SNF-Based HOSPICE									12.00
	SNF-Based CORF									13.00
						From:		To		
						1.00		2.0	0	
	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/	2022	14.00
15.00	Type of Control (See Enstructions)						4			15.00
								Y/I		
	Type of Freestanding Skilled Nursing Facility							1.0	0	
16 00	Is this a distinct part skilled nursing facil		meets the r	requireme	nts set forth	in 42 CER		N		16.00
10.00	section 483.5?	i ty that	meets the i	equi i cilici	113 301 101 111	111 42 011				10.00
17.00	Is this a composite distinct part skilled nur	sing faci	lity that r	meets the	requirements	set forth i	in	N		17.00
	42 CFR section 483.5?	0	3							
	Are there any costs included in Worksheet A t							Y		18.00
	organizations as defined in CMS Pub. 15-1, ch	napter 107	? Ifyes, o	complete \	Norksheet A-8-	-1.				
	Miscellaneous Cost Reporting Information	nost in	di ooto with	o "\/" f		- for no		N		10.00
	If this is a low Medicare utilization cost re If line 19 is yes, does this cost report meet				2		-	N N		19.00 19.01
19.01	utilization cost report, indicate with a "Y",				ioi iiiing a i		5			17.01
	Depreciation - Enter the amount of depreciati				the method ind	dicated on	Li nes	20 - 22		
	Straight Line								263, 573	20.00
21.00	Declining Balance								C	21.00
	Sum of the Year's Digits								C	22.00
	Sum of line 20 through 22							2	263, 573	•
	If depreciation is funded, enter the balance								C	
	Were there any disposal of capital assets dur	5		51	. ,	anting nori		N		25.00 26.00
20.00	Was accelerated depreciation claimed on any a (Y/N)	155615 111	the current	t or any	SITUI COST TEL	boi ting per	ou?	N		20.00
27.00	Did you cease to participate in the Medicare	program a	at end of th	ne period	to which this	s cost repo	rt	N		27.00
	applies? (Y/N)	P 9								
28.00	Was there a substantial decrease in health ir	nsurance p	proportion o	of allowa	ole cost from	prior cost		N		28.00
	reports? (Y/N)								a	
								A Part B		-
	If this facility contains a public or non-put	hlic provi	ider that a	ualifics	for an exampti	on from th	1.00		3.00	
	of the lower of the costs or charges enter "									
	exemption.			i and typ		and quarre	. 55 1	2. 110		
29.00	Skilled Nursing Facility						N	N		29.00
30.00	Nursing Facility								Ν	30.00
	ICF/IID								Ν	31.00
	SNF-Based HHA						N	N		32.00
	SNF-Based RHC									33.00
	SNF-Based FQHC SNF-Based CMHC							N		34.00 35.00
	SNF-Based OLTC							N		35.00
30.00	SNI-Based OLIC					Y/N				30.00
						1.00		2.0	0	
37.00	Is the skilled nursing facility located in a	state tha	at certifies	s the pro	vider as a SNF			2.0	-	37.00
	regardless of the level of care given for Tit									
	Are you legally-required to carry malpractice					N				38.00
39.00	Is the malpractice a "claims-made" or "occurr	rence" pol	icy? If the	e policy	S	1				39.00
	"claims-made" enter 1. If the policy is "occu	urrence",	enter 2.		Premiums	Paid Los	505 I	Self Ins	uranco	
					1.00	2.00	303	3.0		
41.00	List malpractice premiums and paid losses:				1	0		0		41.00

Health Financial Systems	MAPLE GLEN	CENTER		In Lieu	u of Form C	MS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3		1 (2022	Worksheet	S-2
COMPLEX INDENTIFICATION DATA			From 01/0 To 12/3	1/2022	Part I Date/Time	Prepared:
					5/17/2023	
					Y/N	
					1.00	
42.00 Are malpractice premiums and paid loss	es reported in other th	an the Administrati	ive and General c	cost	N	42.00
center? Enter Y or N. If yes, check bo	x, and submit supportin	g schedule listing	cost centers and	k		
amounts.						
43.00 Are there any home office costs as def					Y	43.00
44.00 If line 43 is yes, enter the home offi	ce chain number and ent	er the name and add	dress of the home	e	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 r	ame and address of	the home office	on the	lines	
bel ow.						
45.00 Name: GENESIS HEALTHCARE	Contractor's Name: NOVI	TAS Co	ontractor's Numbe	er: 1200	1	45.00
46.00 Street: 101 EAST STATE STREET	P0 Box:					46.00
47.00 City: KENNETT SQUARE	State: PA	Zi	p Code:	1934	8	47.00

	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der I		Period: From 01/01/2022 To 12/31/2022	Date/Time Pr	epared
					Y/N	5/17/2023 2: Date	38 pm
					1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy)	ses enter in column	1, "Y" for	Yes or "N"	for No. For all	the date	
	Completed by All Skilled Nursing Facilites						_
00	Provider Organization and Operation Has the provider changed ownership immediate	ly prior to the bea	unning of t	the cost	N		1.
00	reporting period? If column 1 is "Y", enter instructions)	the date of the cha	inge in colu	umn 2. (see			
				Y/N	Date	V/I	
00	lles the provider terminated participation in	the Medicane Dream	am2 lf	1.00 N	2.00	3.00	2.
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date			IN			2.
	3, "V" for voluntary or "I" for involuntary.						
00	Is the provider involved in business transac			Y			3.
	contracts, with individuals or entities (e.g or medical supply companies) that are related						
	officers, medical staff, management personnel						
	of directors through ownership, control, or	family and other si	milar				
	relationships? (see instructions)			Y/N	Tuno	Date	
			ŀ	1.00	Type 2.00	3.00	-
	Financial Data and Reports						
00	Column 1: Were the financial statements prepa			Y	А	03/27/2023	4
	Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple						
	available in column 3. (see instructions) If						
0	Are the cost report total expenses and total			N			5
	those on the filed financial statements? If	column 1 is "Y", su	ıbmi t				
	reconciliation.				Y/N	Legal Oper.	
					1.00	2.00	
	Approved Educational Activities						
~	Column 1. Ware control of a March Col				NI	NI	
0	Column 1: Were costs claimed for Nursing Schulegal operator of the program? (Y/N)	ool? (Y/N) Column 2	∷ Is the p	provider the	N	N	6
	Column 1: Were costs claimed for Nursing Schulegal operator of the program? (Y/N) Were costs claimed for Allied Health Program:	. ,		provider the	N	N	
0	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri	s? (Y/N) see instru ng the cost reporti	Icti ons.			N	7
0	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program:	s? (Y/N) see instru ng the cost reporti	Icti ons.		N		7
0	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri	s? (Y/N) see instru ng the cost reporti	Icti ons.		N	N <u>Y/N</u> 1.00	7
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) se Bad Debts	s? (Y/N) see instru ng the cost reporti ee instructions.	ng period 1	for Nursing	N	Y/N 1.00	7 8
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac	s? (Y/N) see instrung the cost reporti ee instructions. d debts? (Y/N) see	instructions.	for Nursing	NN	Y/N 1.00 Y	7 8
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) se Bad Debts	s? (Y/N) see instrung the cost reporti ee instructions. d debts? (Y/N) see	instructions.	for Nursing	NN	Y/N 1.00	7 8
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Heal th	Financial Systems MAPLE GLE	N CEN	NTER			In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE		Provi der	No.: 315328		ri od:	Worksheet S-2	2
COMPLE	X REI MBURSEMENT QUESTI ONNAI RE	_			To	om 01/01/2022 12/31/2022	Part II Date/Time Pre 5/17/2023 2:3	epared: 38 pm
			1.	00		2.0	00	
	Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the title/position	JEAN			PI	RICE		19.00
	held by the cost report preparer in columns 1, 2, and 3,							
	respecti vel y.							
20.00	Enter the employer/company name of the cost report	GENE	SIS HEALTH	CARE				20.00
	preparer.							
21.00	Enter the telephone number and email address of the cost	4108	044481		JL	EAN. PRI CE@GENE	SI SHCC. COM	21.00
	report preparer in columns 1 and 2, respectively.							

Heal th	Financial Systems	MAPLE GLEN C	ENTER	In Lieu	u of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provi der No.: 315328	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/17/2023 2:3	pared:
		Part B Date				
		4.00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)					13. 00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	03/15/2023				14. 00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15. 00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
			3.00	_		
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title held by the cost report preparer in columns 7 respectively.		IMBURSEMENT ANALYST			19. 00
20.00	Enter the employer/company name of the cost r preparer.	report				20. 00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	Financial Systems D NURSING FACILITY AND SKILLED NURSIN	MAPLE GLEN		No.: 315328 Pe	In Lieu eriod:	u of Form CMS-2 Worksheet S-3	2040-
PLE	X STATISTICAL DATA	J FACILITI HLALIH CARL	FIOVICEI		rom 01/01/2022	Part I	
				To	0 12/31/2022	Date/Time Prep	
	· · · · · · · · · · · · · · · · · · ·			Inpa	atient Days/Vis	<u>5/17/2023 2:38</u> its	o piii
				The	terone buys, vrs	113	
	Component	Number of Beds	Bed Days	Title V	Title XVIII	Title XIX	
			Avai I abl e				
		1.00	2.00	3.00	4.00	5.00	1
0 0	SKILLED NURSING FACILITY NURSING FACILITY	161	58, 765 0	0	3, 027	34, 181 0	1. 2.
0		0	0	0		0	3.
0	HOME HEALTH AGENCY COST		0	0	о	Ő	4.
0	Other Long Term Care	0	0				5.
0	SNF-Based CMHC						6.
0	SNF-Based CORF						6.
0	HOSPI CE	0	0	0	0	0	7.
0	Total (Sum of lines 1-7)	161 Inpatient D	58, 765	0	3, 027 Di scharges	34, 181	8.
		Inpatrent b	ays/visits		Di schai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	1	6.00	7.00	8.00	9.00	10.00	
0	SKILLED NURSING FACILITY	4, 154	41, 362	0	59	84	1.
0	NURSING FACILITY	0	0	0		0	2. 3.
0	HOME HEALTH AGENCY COST	0	0			0	4.
0	Other Long Term Care	0	0				5.
0	SNF-Based CMHC		-				6.
0	SNF-Based CORF						6.
00	HOSPICE	0	0	0	0	0	7.
0	Total (Sum of lines 1-7)	4, 154 Di scha	41, 362	0	59 age Length of S	84	8.
		DISCHA	ai ges	Aver	age Length of S	btay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	90	233	0.00	51.31	406. 92	1.
00 00	NURSING FACILITY	0	0	0.00		0.00 0.00	2. 3.
0	HOME HEALTH AGENCY COST		0			0.00	4.
0	Other Long Term Care	0	0				5.
00	SNF-Based CMHC						6.
0	SNF-Based CORF						6.
00	HOSPICE	0 90	0	0.00	0.00	0.00	7.
00	Total (Sum of lines 1-7)	Average Length	233	0. 00 Admi s	51.31 si ons	406.92	8.
		of Stay		/ tollin C			
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	<u> </u>	18.00 90	19.00 37	20.00	1.
0 0	SKILLED NURSING FACILITY NURSING FACILITY	177. 52 0. 00	0	90	37	124 0	2.
0		0.00	0		0	0	3.
0	HOME HEALTH AGENCY COST						4.
0	Other Long Term Care	0.00				0	5.
0	SNF-Based CMHC						6.
0	SNF-Based CORF	0.00	0	0	0	0	6.
0 0	HOSPICE Total (Sum of lines 1-7)	0. 00 177. 52	0	0 90	0 37	0 124	7. 8.
0		Admi ssi ons	Full Time		37	124	0.
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22.00	Workers 23.00			
	SKILLED NURSING FACILITY	21.00	83.24				1.
0	NURSING FACILITY	0	0.00				2.
	ICF/IID	0	0.00				3.
0	LUONE LEALTH AGENOV COST		0.00				4.
0 0	HOME HEALTH AGENCY COST	1 1		0 00			5.
0 0 0 0	Other Long Term Care	0	0.00				
	Other Long Term Care SNF-Based CMHC	0	0.00	0.00			6.
00 00 00 00 00 00 00	Other Long Term Care	0		0. 00 0. 00			6. 6. 7.

Heal th	Financial Systems	MAPLE GLE	N CENTER		In Lie	eu of Form CMS-2	2540-10
	GE INDEX INFORMATION				Period: From 01/01/2022 To 12/31/2022		pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART I I – DI RECT SALARI ES						
	SALARI ES						
1.00	Total salaries (See Instructions)	5, 225, 839	C	5, 225, 83	9 173, 131. 00	30. 18	1.00
2.00	Physician salaries-Part A	0	C)	0 0.00	0.00	2.00
3.00	Physician salaries-Part B	0	C		0 0.00		3.00
4.00	Home office personnel	0	C		0 0.00		4.00
5.00	Sum of lines 2 through 4	0	C		0 0.00		5.00
6.00	Revised wages (line 1 minus line 5)	5, 225, 839	C	5, 225, 83	9 173, 131. 00	30. 18	6.00
7.00	Other Long Term Care	0	C		0 0.00		7.00
8.00	HOME HEALTH AGENCY COST	0	C		0 0.00		
9.00	СМНС	0	C		0 0.00	0.00	9.00
9.10	CORF						9.10
10.00	HOSPICE	0	C		0 0.00		
11.00	Other excluded areas	0	C		0 0.00		
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	C		0 0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line	5, 225, 839	C	5, 225, 83	9 173, 131. 00	30. 18	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	3, 012, 710					14.00
15.00	Contract Labor: Physician services-Part A	97, 016					
16.00	Home office salaries & wage related costs	432, 937	C	432, 93	7 8, 816.00	49.11	16.00
47 00	WAGE-RELATED COSTS	704 504			-		47.00
17.00	Wage-related costs core (See Part IV)	701, 521	C	701, 52	1		17.00
18.00	Wage-related costs other (See Part IV)	0	C)	0		18.00
19.00	Wage related costs (excluded units)	0	C C		0		19.00
20.00	Physician Part A - WRC	0	C		0		20.00
21.00	Physician Part B - WRC	0	C	704 50	0		21.00
22.00	Total Adjusted Wage Related cost (see	701, 521	C	701, 52	1		22.00
	instructions)			I	I	I	

Heal th	Financial Systems	MAPLE GLE	N CENTER		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2022 To 12/31/2022		pared [.]
						5/17/2023 2: 3	
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
		1.00	2.00	2.00	3	F 00	
	PART III - OVERHEAD COST - DIRECT SALARIES	1.00	2.00	3.00	4.00	5.00	
	Employee Benefits	0	0		0 0.00	0.00	1.00
	Administrative & General	482, 917	0	482, 91			2.00
	Plant Operation, Maintenance & Repairs	100, 487		100, 48			3.00
4.00	Laundry & Linen Service	0	0		0 0.00		4.00
5.00	Housekeepi ng	0	0		0 0.00	0.00	5.00
6.00	Dietary	0	0		0.00	0.00	6.00
7.00	Nursing Administration	568, 851	-96, 774	472, 07	7 10, 884.00	43.37	7.00
8.00	Central Services and Supply	0	55, 251	55, 25	1 2, 224. 00	24.84	8.00
9.00	Pharmacy	0	0		0 0.00	0.00	9.00
	Medical Records & Medical Records Library	0	41, 523	41, 52	3 1, 931. 00	21.50	10.00
	Soci al Servi ce	169, 582	0	169, 58	2 5, 111. 00	33.18	
	Nursing and Allied Health Ed. Act.						12.00
	Other General Service	141, 195		141, 19			13.00
14.00	Total (sum lines 1 thru 13)	1, 463, 032	0	1, 463, 03	2 47, 249. 00	30.96	14.00

alth Financial Systems	MAPLE GLEN CEN			u of Form CMS-2	2540-10
IF WAGE RELATED COSTS		Provider No.: 315328	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Pre 5/17/2023 2:33	pared:
				Amount Reported	
				1.00	
PART IV - WAGE RELATED COSTS					
Part A - Core List					
RETI REMENT COST					1
00 401K Employer Contributions				0	1.00
00 Tax Sheltered Annuity (TSA) Employer	Contri buti on			0	2.00
00 Qualified and Non-Qualified Pension I	Plan Cost			0	3.00
00 Prior Year Pension Service Cost				0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to E>	(ternal Organization)				
00 401K/TSA Plan Administration fees	<u> </u>			0	5.00
00 Legal /Accounting/Management Fees-Pens	sion Plan			0	6.00
00 Employee Managed Care Program Adminis	stration Fees			0	7.00
HEALTH AND INSURANCE COST					
00 Health Insurance (Purchased or Self I	Funded)			135, 948	8.00
00 Prescription Drug Plan				0	9.00
0.00 Dental, Hearing and Vision Plan				0	10.00
.00 Life Insurance (If employee is owner	or beneficiary)			0	11.00
2.00 Accident Insurance (If employee is o	wner or beneficiary)			0	12.0
8.00 Disability Insurance (If employee is	owner or beneficiary)			0	13.0
.00 Long-Term Care Insurance (If employed	e is owner or beneficiary)			0	14.0
5.00 Workers' Compensation Insurance				138, 179	15.0
.00 Retirement Health Care Cost (Only cu	rrent year, not the extraord	linary accrual require	d by FASB 106.	0	16.0
Non cumulative portion)	-				1
TAXES					I
7.00 FICA-Employers Portion Only				377, 920	17.00
8.00 Medicare Taxes - Employers Portion Or	nl y			0	18.0
0.00 Unemployment Insurance				0	19.00
0.00 State or Federal Unemployment Taxes				32, 132	20.00
OTHER					I
.00 Executive Deferred Compensation				0	21.0
2.00 Day Care Cost and Allowances				0	22.00
8.00 Tuition Reimbursement				17, 342	
.00 Total Wage Related cost (Sum of lines	5 1 - 23)			701, 521	24.00
				Amount	
				Reported	
				1.00	
Part B - Other than Core Related Cost					25 00
5.00 OTHER WAGE RELATED COSTS (SPECIFY)				0	25.0

Heal th	Financial Systems	MAPLE GLEN	CENTER		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES				Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V	oared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 677, 881	190, 823				1.00
2.00	Licensed Practical Nurses (LPNs)	565, 329	82, 321				2.00
3.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	1, 519, 597	229, 942	1, 749, 53	75, 666. 24	23. 12	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3, 762, 807	503, 086	4, 265, 89			4.00
5.00	Physical Therapists	0	0		0 0.00		5.00
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	0	0		0 0.00		7.00
8.00	Occupational Therapists	0	0		0 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		
11.00	Speech Therapists	0	0		0 0.00		11.00
12.00	Respiratory Therapists	0	0		0 0.00		12.00
13.00	Other Medical Staff	0	0		0 0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	57, 167		57, 16			
15.00	Licensed Practical Nurses (LPNs)	304, 868		304, 86			15.00
16.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	575, 624		575, 62	13, 815. 38	41.67	16.00
17.00	Total Nursing (sum of lines 14 through 16)	937, 659		937, 65	9 19, 122. 58	49.03	17.00
18.00	Physical Therapists	331, 414		331, 41	4 4, 628.00	71.61	18.00
19.00	Physical Therapy Assistants	5, 716		5, 71	6 108.00	52.93	19.00
20.00	Physical Therapy Aides	0			0 0.00	0.00	20.00
21.00	Occupational Therapists	238, 897		238, 89	3, 952. 00	60.45	21.00
22.00	Occupational Therapy Assistants	64, 324		64, 32	4 1, 464. 00	43.94	22.00
23.00	Occupational Therapy Aides	0			0 0.00	0.00	23.00
24.00	Speech Therapists	118, 509		118, 50	1, 987. 00	59.64	24.00
25.00	Respiratory Therapists	2, 556		2, 55	6 53.00		25.00
26.00	Other Medical Staff	97, 016		97, 01	6 1, 141. 00	85.03	26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	MAPLE GLEN CEN	ITER Provider No.: 315328	Peri od:	u of Form CMS Worksheet S	
			From 01/01/2022 To 12/31/2022	Date/Time Pr	repared:
			Group	5/17/2023 2: Days	38 pm
1.00			1.00	2.00	1.00
1.00 2.00			RUX RUL		1.00
3. 00			RVX		3.00
4.00			RVL		4.00
5.00 6.00			RHX RHL		5.00 6.00
7.00			RMX		7.00
8.00 9.00			RML RLX		8.00 9.00
10.00			RUC		10.00
11.00			RUB		11.00
12. 00 13. 00			RUA RVC		12.00 13.00
14.00			RVB		14.00
15.00			RVA		15.00
16. 00 17. 00			RHC RHB		16.00 17.00
18.00			RHA		18.00
19.00			RMC		19.00
20. 00 21. 00			RMB RMA		20.00
22.00			RMA RLB		21.00
23. 00			RLA		23.00
24. 00 25. 00			ES3 ES2		24.00 25.00
26.00			ES1		25.00
27.00			HE2		27.00
28.00			HE1 HD2		28.00
29. 00 30. 00			HD2 HD1		29.00 30.00
31. 00			HC2		31.00
32.00			HC1		32.00
33. 00 34. 00			HB2 HB1		33.00 34.00
35. 00			LE2		35.00
36.00			LE1		36.00
37. 00 38. 00			LD2 LD1		37.00 38.00
39.00			LC2		39.00
40.00			LC1		40.00
41. 00 42. 00			LB2 LB1		41.00
43.00			CE2		43.00
44.00			CE1		44.00
45.00 46.00			CD2 CD1		45.00 46.00
47.00			CC2		47.00
48.00			CC1		48.00
49. 00 50. 00			CB2 CB1		49.00 50.00
51.00			CA2		51.00
52.00 53.00			CA1 SE3		52.00 53.00
53.00			SE3 SE2		53.00
55. 00			SE1		55.00
56.00			SSC		56.00
57.00 58.00			SSB SSA		57.00 58.00
59. 00			I B2		59.00
60.00			I B1		60.00
61.00 62.00			I A2 I A1		61.00 62.00
63.00			BB2		63.00
64. 00 65. 00			BB1		64.00
65. 00 66. 00			BA2 BA1		65.00 66.00
67.00			PE2		67.00
68.00			PE1		68.00
69. 00 70. 00			PD2 PD1		69.00 70.00
71.00			PC2		71.00
72.00			PC1		72.00
73.00 74.00			PB2 PB1		73.00
75.00			PBT PA2		74.00

Health Financial Systems	MAPLE GLEN CEM	ITER		In Lie	u of Form CM	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315328	Period:	Worksheet S	-7
				From 01/01/2022 To 12/31/2022		repared: :38 pm
				Group	Days	
				1.00	2.00	
76.00				PA1		76.00
99.00				AAA		99.00
100. 00 TOTAL						100.00
			Expenses	Percentage	Y/N	
			1.00	2.00	3.00	
A notice published in the Federal Register Vo payments beginning 10/01/2003. Congress expec expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fo with direct patient care and related expenses (See instructions)	ted this increase column 1 the amou each category to r yes or "N" for n	to be used nt of the total SNF o if the s	for direct expense for revenue from pending refl	batient care and each category. Er Worksheet G-2, F ects increases as	related iterin PartI, ssociated	
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, lin	e 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

ECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/17/2023 2:3	
	Cost Center Description	Sal ari es	Other	Total (col. 7 + col. 2)	I Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1	1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	T T			-		
. 00 . 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		2, 092, 921 69, 594			2, 092, 921 69, 594	1.00
. 00	00300 EMPLOYEE BENEFITS	0	684, 927			684, 927	3.00
. 00	00400 ADMI NI STRATI VE & GENERAL	482, 917	2, 258, 867			2, 741, 784	
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	100, 487	422, 076			522, 563	
. 00	00600 LAUNDRY & LINEN SERVICE	0	239, 045			239, 045	
. 00	00700 HOUSEKEEPI NG	0	272, 038	272, 03	8 0	272, 038	7.00
. 00	00800 DI ETARY	0	1, 084, 954			1, 084, 954	8.0
. 00	00900 NURSI NG ADMI NI STRATI ON	568, 851	37, 369			509, 446	
0.00	01000 CENTRAL SERVICES & SUPPLY	0	26, 811	26, 81		82, 062	
1.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0		0 0 0 41, 523	0 41, 523	11.0 12.0
3.00	01300 SOCIAL SERVICE	169, 582	1, 485	171, 06		171, 067	13.00
4.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.0
5.00	01500 ACTI VI TI ES	141, 195	23, 929	165, 12	4 0	165, 124	15.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 SKILLED NURSING FACILITY	3, 762, 807	1, 088, 802	4, 851, 60	9 0	4, 851, 609	
1.00	03100 NURSING FACILITY	0	0		0 0	0	31.0
2.00		0	0		0 0	0	
3.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	33.0
0. 00	04000 RADI OLOGY	0	11, 132	11, 13	2 0	11, 132	40.0
1.00	04100 LABORATORY	0	40, 170			40, 170	
2.00	04200 INTRAVENOUS THERAPY	0	21, 402			21, 402	
3.00	04300 OXYGEN (INHALATION) THERAPY	0	20, 245	20, 24	5 0	20, 245	43.0
4.00	04400 PHYSI CAL THERAPY	0	263, 902	263, 90	2 0	263, 902	44.0
5.00	04500 OCCUPATIONAL THERAPY	0	347, 604			347, 604	
6.00		0	148, 338			148, 338	
7.00 8.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	47.0 48.0
9.00	04900 DRUGS CHARGED TO PATIENTS	0	136, 752	136, 75	2 0	136, 752	
0.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	100,70	0 0	0	50.0
1.00	05100 SUPPORT SURFACES	0	4, 085	4, 08	5 0	4, 085	
2.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	52.0
	OUTPATIENT SERVICE COST CENTERS	11			_		
0.00	06000 CLINIC	0	0		0 0		
1.00 2.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0	61.0 62.0
3.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		o o	0	
0.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		
0. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.0
1.00	07100 AMBULANCE	0	0		0 0	0	71.0
2.00	07200 CORF	0	0		0 0	0	
3.00		0	0		0 0	0	
4.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	74.0
0. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	1	0 0	0	80.00
1.00	08100 I NTEREST EXPENSE		0		0 0	0	
2.00	08200 UTI LI ZATI ON REVI EW	0	0		0 0	0	
3.00	08300 HOSPI CE	0	0		0 0	0	83.0
4.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	
9.00	SUBTOTALS (sum of lines 1-84)	5, 225, 839	9, 296, 448	14, 522, 28	7 0	14, 522, 287	89.0
0 00	NONREI MBURSABLE COST CENTERS				0 0	0	
0.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 6, 997			6, 997	
2.00	09200 PHYSICIANS PRIVATE OFFICES	0	0, 777 N	0, 77	0 0	0, 337	
3.00		o	0		0 0	0	
4.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	
5.00		0	0		0 0	0 14, 529, 284	
00.00	TOTAL	5, 225, 839	9, 303, 445	14, 529, 28			

LAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES	Provi der	No.: 315328		Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	
	Cost Center Description	Adjustments to	Net Exnenses			5/17/2023 2:3	38 pm
	cost center bescription	Expenses (Fr F					
		Wkst A-8)	(col. 5 +-				
		(<u>col. 6)</u>	-			
	GENERAL SERVICE COST CENTERS	6.00	7.00				-
0	00100 CAP REL COSTS - BLDGS & FIXTURES	0	2, 092, 921				1 1.
0	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	69, 594				2
0	00300 EMPLOYEE BENEFITS	39, 022	723, 949	1			3
0	00400 ADMINI STRATI VE & GENERAL	-821, 828	1, 919, 956	1			4
0	00500 PLANT OPERATION, MAINT. & REPAIRS	0	522, 563				5
0	00600 LAUNDRY & LINEN SERVICE	0	239, 045				6
0	00700 HOUSEKEEPI NG	0	272, 038				7
0	00800 DI ETARY	0	1, 084, 954				8
0	00900 NURSI NG ADMI NI STRATI ON	0	509, 446				9
00	01000 CENTRAL SERVICES & SUPPLY	0	82, 062				10
		0	0				11
	01200 MEDI CAL RECORDS & LI BRARY	0	41, 523				12
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	171, 067				13
	01500 ACTIVITIES	-18, 528	146, 596				14
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-10, 520	140, 370	1			- 13
00	03000 SKI LLED NURSI NG FACI LI TY	-40, 134	4, 811, 475				30
	03100 NURSING FACILITY	0	C	1			31
00	03200 I CF/I I D	0	C				32
00	03300 OTHER LONG TERM CARE	0	C				33
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	0	11, 132	1			40
	04100 LABORATORY	0	40, 170	1			41
	04200 I NTRAVENOUS THERAPY	0	21, 402				42
	04300 OXYGEN (INHALATION) THERAPY	0	20, 245	1			43
00 00	04400 PHYSI CAL THERAPY	0	263, 902	1			44
	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	347, 604 148, 338	1			45
	04700 ELECTROCARDI OLOGY	0	140, 330	1			47
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ő	Ő				48
	04900 DRUGS CHARGED TO PATIENTS	0	136, 752				49
	05000 DENTAL CARE - TITLE XIX ONLY	0	0				50
00	05100 SUPPORT SURFACES	0	4, 085				51
00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0				52
	OUTPATIENT SERVICE COST CENTERS						
	06000 CLINIC	0	0	1			60
	06100 RURAL HEALTH CLINIC	0	0				61
	06200 FQHC		~				62
00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	1			63
00	07000 HOME HEALTH AGENCY COST	0	0				70
	07100 AMBULANCE	0	0				71
	07200 CORF	0	0				72
	07300 CMHC	o o	C				73
	07400 OTHER REIMBURSABLE COST	0	0	•			74
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	C				80
	08100 INTEREST EXPENSE	0	C				81
	08200 UTI LI ZATI ON REVI EW	0	0				82
00		0	0				83
	08400 OTHER SPECIAL PURPOSE COST CENTERS	0 41 4 4	12 (00, 010				84
00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	-841, 468	13, 680, 819	1			89
00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90
	09100 BARBER AND BEAUTY SHOP	0	6, 997				91
	09200 PHYSI CLANS PRI VATE OFFICES	0	0, 777				92
	09300 NONPALD WORKERS	0	0				93
	09400 PATIENTS LAUNDRY	o o	C				94
	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0				95
. 00	TOTAL	-841, 468	13, 687, 816	I			100

Health Financial Systems	MAPLE GLEN CENTER			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provider No.: 315328		Period: From 01/01/2022	Worksheet A-6		
				Date/Time Pre			
					5/17/2023 2:3	<u>8 pm</u>	
			Increases				
	Cost Center	r i i	Line #	Sal ary	Non Salary		
	2.00		3.00	4.00	5.00		
(1) A - DEFAULT							
1.00	CENTRAL SERVICES &	SUPPLY	10. (55, 251	0	1.00	
2.00	MEDICAL RECORDS & L	I BRARY	12. (41, 523	0	2.00	
TOTALS						1	
100.00	Total Reclassificat	ions (Sum		96, 774	0	100.00	
	of columns 4 and 5 must						
	equal sum of column						
	9)						
1	1.7			i.		1	

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.

Health Financial Systems	MAPLE GLEN CEN	TER		In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS				Period: From 01/01/2022	Worksheet A-6		
					Date/Time Prep 5/17/2023 2:38	oared: 3 pm	
	Decreases						
	Cost Cente	ŕ	Line #	Sal ary	Non Salary		
	6.00		7.00	8.00	9.00		
(1) A - DEFAULT							
1.00	NURSING ADMINISTRAT	I ON	9.	55, 251	0	1.00	
2.00	NURSING ADMINISTRAT	I ON	9.	0 41, 523	0	2.00	
TOTALS							
100.00				96, 774	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.

	n Financial Systems	MAPLE GLEN			In Lieu of Form CMS-2		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315328	Peri od:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		oorod.
					10 12/31/2022	5/17/2023 2:38	Binm
				Acqui si ti on	S	0/1//2020 2:00	
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BAL	ANCES					
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	282, 992	0		0 0	0	2.00
3.00	Buildings and Fixtures	4, 952, 411	0		0 0	0	3.00
4.00	Building Improvements	1, 407, 914	106, 383		0 106, 383	0	4.00
5.00	Fixed Equipment	289, 486	34, 609		0 34, 609	0	5.00
6.00	Movable Equipment	908, 590	3, 690		0 3, 690	0	6.00
7.00	Subtotal (sum of lines 1-6)	7, 841, 393	144, 682		0 144, 682	0	7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	7, 841, 393	144, 682		0 144, 682	0	9.00
	Description	Endi ng Bal ance	Fully				
		-	Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BAL	ANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	282, 992	0				2.00
3.00	Buildings and Fixtures	4, 952, 411	0				3.00
4.00	Building Improvements	1, 514, 297	0				4.00
5.00	Fixed Equipment	324, 095	0				5.00
6.00	Movable Equipment	912, 280	0				6.00
7.00	Subtotal (sum of lines 1-6)	7, 986, 075	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	7, 986, 075	0				9.00

	Financial Systems MENTS TO EXPENSES		Provi der	No.: 315328	Peri od:	Worksheet A-8	2540-
					From 01/01/2022 To 12/31/2022	Date/Time Pre	parec
						5/17/2023 2:3	<u>8 pm</u>
					lassification on ch the Amount is		
						,	
	Description (1)	(2) Basis For Adjustment	Amount	Cos	t Center	Line No.	
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds (chapter 2)		0			0.00	1.
00	Trade, quantity, and time discounts (chapter		0			0.00	2.
	8)		_				
00 00	Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers		0			0.00 0.00	
50	(chapter 8)		0			0.00	4.
00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	5.
00	Television and radio service (chapter 21)	А	-18, 528	ACTI VI TI ES		15.00	6.
00	Parking lot (chapter 21)		0			0.00	
00	Remuneration applicable to provider-based	A-8-2	0				8.
00	physician adjustment Home office cost (chapter 21)		0			0.00	9
00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
00	Nonallowable costs related to certain		0			0.00	11.
~~	Capital expenditures (chapter 24)	4.0.1	070 107				10
. 00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	278, 107				12.
00	Laundry and Linen service		0			0.00	13.
	Revenue - Employee meals		0			0.00	
00	Cost of meals - Guests		0			0.00	
00	Sale of medical supplies to other than patients		0			0.00	16.
00	Sale of drugs to other than patients		0			0.00	17
00	Sale of medical records and abstracts		0			0.00	
00	Vending machines		0			0.00	
00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20
. 00	Interest expense on Medicare overpayments		0			0.00	21.
	and borrowings to repay Medicare						
00	overpayments Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	DEVI EW	82.00	22.
00	(chapter 21)		0	UTILIZATION	KLVI LW	02.00	22
00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23.
00	Depreciationmovable equipment		0	FIXTURES CAP REL COST	S - MOVABLE	2.00	24
				EQUI PMENT			
	MISC INCOME	В			VE & GENERAL	4.00	
01	UNALLOWED A & G	A			VE & GENERAL	4.00	
02	WORKERS COMPENSATION	A		EMPLOYEE BEN		3.00	
	HEPARIN/SALINE Total (sum of lines 1 through 99) (Transfer	A	-841, 468		ING FACILITY	30.00	100.
	to Worksheet A, col. 6, line 100)		541, 100				00.
	scription - all chapter references in this co	lumn pertain to	CMS Pub. 15-1				
	sis for adjustment (see instructions). osts – if cost, including applicable overhead.						

Health Financial Systems	MAPLE GLEN	I CENTER		In Lieu of Form CMS-254		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS				Period: From 01/01/2022 To 12/31/2022	5/17/2023 2:	epared:
	Line No.	Cost (Expense	e Items	
	1.00	2.		3.		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	5 OR	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE A&C	3	1.00
2.00	4.00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE CAR	PITAL	2.00
3.00	44.00	PHYSICAL THERA	PY	PT		3.00
4.00	45.00	OCCUPATI ONAL T	HERAPY	OT		4.00
5.00	46.00	SPEECH PATHOLO	GY	ST		5.00
6.00	30. 00	SKILLED NURSIN	G FACILITY	NURSING PURCHAS	SED SERVICES	6.00
7.00	43.00	OXYGEN (INHALA	TION) THERAPY	RT		7.00
8.00	4.00	ADMI NI STRATI VE	& GENERAL	MEDICAL DIRECTO	OR	8.00
9.00	0. 00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line						
12.			-			
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu	S		
	Cost	Wkst. A, col.	col. 5)			
		5				
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	5 OR	
1.00	685, 547	445, 261	240, 28	86		1.00
2.00	78, 610	0	78, 61	0		2.00
3.00	263, 780	263, 780		0		3.00
4.00	347, 576	347, 576		0		4.00
5.00	148, 302	148, 302		0		5.00
6.00	896, 870	937, 659	-40, 78	19		6.00
7.00	16, 027	16, 027		0		7.00
8.00	97, 016	97, 016		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	2, 533, 728	2, 255, 621	278, 10)7		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						

Health Financial Systems	MAPLE GLE	N CEN	TER	In Lie	u of Form CMS-2	540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOM	IE	Provider No.: 315328	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8- Parts I-II Date/Time Prep 5/17/2023 2:38	bared:
	Symbol (1)		Name	Percentage of Ownership		
	1.00		2.00	3.00		

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

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

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

1.00	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.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in

related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of	Type of Business	
		Ownership	51	
	4.00	5.00	6.00	1
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(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.

i i proposo di si			
1.00	GENESIS HEALTHCARE	100.00MANAGEMENT COMPANY	1.00
2.00	POWERBACK	100.00 PT OT ST	2.00
3.00	CAREER STAFF UNLIMITED	100.00 NURSI NG PURCHASED SERVI CES	3.00
4.00	POWERBACK RESPI RATORY	100.00 RT	4.00
5.00	GENESIS PHYSICIAN SERVICES	100.00 MEDI CAL DI RECTOR	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems	MAPLE GLEN				u of Form CMS-	2540-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre	paradi
				o 12/31/2022	5/17/2023 2:3	
		CAPITAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
	(from Wkst A					
	col. 7) 0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS		0.000.001				
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES 2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT	2, 092, 921 69, 594	2, 092, 921	69, 594	L		1.00
3. 00 00300 EMPLOYEE BENEFITS	723, 949	50, 442				3.00
4. 00 00400 ADMI NI STRATI VE & GENERAL	1, 919, 956	152, 960			2, 149, 718	
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS 6. 00 00600 LAUNDRY & LINEN SERVICE	522, 563 239, 045	124, 048 50, 724			665, 659 291, 456	
7. 00 00700 HOUSEKEEPI NG	272, 038	23, 108			295, 914	•
8. 00 00800 DI ETARY	1, 084, 954	232, 935			1, 325, 635	
9.00 00900 NURSI NG ADMI NI STRATI ON	509, 446	38, 268			619, 093	
10. 00 01000 CENTRAL SERVICES & SUPPLY 11. 00 01100 PHARMACY	82,062	0			90, 267 0	10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	41, 523	45, 426	1, 511	6, 166	94, 626	•
13.00 01300 SOCIAL SERVICE	171,067	7, 890			204, 403	
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITIES	0 146, 596	0			0 167, 564	14.00
INPATIENT ROUTINE SERVICE COST CENTERS	140, 390	0	1	20, 700	107, 304	15.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	4, 811, 475	1, 284, 327	42, 705	558, 800	6, 697, 307	30.00
31.00 03100 NURSING FACILITY	0	0			0	31.00
32. 00 03200 I CF/I I D 33. 00 03300 OTHER LONG TERM CARE	0	0			0	32.00 33.00
ANCI LLARY SERVICE COST CENTERS						00.00
40. 00 04000 RADI OLOGY	11, 132	0			11, 132	•
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY	40, 170 21, 402	0			40, 170 21, 402	
43. 00 04300 OXYGEN (INHALATION) THERAPY	20, 245	0			21, 402 20, 245	
44. 00 04400 PHYSI CAL THERAPY	263, 902	43, 961			309, 325	•
45.00 04500 OCCUPATI ONAL THERAPY	347, 604	20, 233			368, 510	1
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	148, 338	0			148, 338 0	46.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 681			13, 103	•
49.00 04900 DRUGS CHARGED TO PATIENTS	136, 752	5, 918			142, 867	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	50.00
51.00 05100 SUPPORT SURFACES 52.00 05200 OTHER ANCI LLARY SERVICE COST CENTERS	4, 085 0	0			4, 085 0	1
OUTPATIENT SERVICE COST CENTERS		0			0	52.00
60. 00 06000 CLINIC	0	0			0	60.00
61. 00 06100 RURAL HEALTH CLINIC 62. 00 06200 F0HC	0	0	0	0 0	0	61.00 62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
OTHER REIMBURSABLE COST CENTERS			I	1		
70. 00 07000 HOME HEALTH AGENCY COST 71. 00 07100 AMBULANCE	0	0			0	70.00
71. 00 07100 AMBULANCE 72. 00 07200 CORF	0	0			0	71.00
73.00 07300 CMHC	0	0	0	o o	0	
74.00 07400 OTHER REI MBURSABLE COST	0	0	(0 0	0	74.00
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 08100 I NTEREST EXPENSE						81.00
82.00 08200 UTI LI ZATI ON REVI EW						82.00
83. 00 08300 HOSPI CE 84. 00 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0	(0	0	
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 89.00 SUBTOTALS (sum of lines 1-84)	13, 680, 819	2, 092, 921	69, 594	776, 068	0 13, 680, 819	84.00 89.00
NONREI MBURSABLE COST CENTERS		_, , , , , , , , , , , , , , , , , , ,			,,,,	1
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSI CLANS PRI VATE OFFICES	6, 997	0	(6, 997 0	91.00 92.00
93. 00 09300 NONPAID WORKERS	0	0			0	92.00
94.00 09400 PATIENTS LAUNDRY	0	0		o o	0	94.00
95.00 09500 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	95.00
98.00Cross Foot Adjustments99.00Negative Cost Centers	0	0			0	98.00 99.00
100.00 TOTAL	13, 687, 816	2, 092, 921	69, 594	776, 068	13, 687, 816	
			•			•

Case Center Description AdMINISTRATIVE & CENERAL OPLATT (MAINT & A CENERAL LAUNDRY & DEVENT HOUSEKEEPING DIETARY DIETARY Center Description Ad.00 5.60 0		Financial Systems	MAPLE GLEN		No . 215220		u of Form CMS-	2540-10
B CENERAL INT A INT	COST A	LLOCATION - GENERAL SERVICE COSIS		Provi der	F	rom 01/01/2022		
EINTERAL SERVICE COST CENTERS 0.00000 CAP REL COSTS - BLOSS & FLYURERS 2.000 OO2000 CAP REL COSTS - MOVABLE CULINMENT 4.000 OO2000 CAP REL COSTS - MOVABLE CULINMENT 4.000 OO2000 CAP REL COSTS - MOVABLE CULINMENT 4.000 OO2000 CAP REL COSTS - MOVABLE CULINMENT 6.000 COSCOLAMINTY SITURE & GUENENT 6.000 COSCOLAMINTY SITURE SERVICE 6.000 COSCOLAMINTY SITURE SERVICE 6.000 COSCOLAMINTY SITURE SERVICE 6.000 COSCOLAMINTY SITURE SERVICE 6.0000 COSCOLAMINTY SITURE SERVICE 6.0000 COSCOLAMINTY SITURE SERVICE 6.0000 COSCOLAMINTY SITURE SERVICE 6.00000 COSCOLAMINTY SITURE SERVICE 6.0000000000 COSCOLAMINTINE SERVICE COST CENTERS 7.000000000000000000000000000000000000		Cost Center Description		OPERATION, MAINT. &				
1.00 00100 CAP FEL COSTS - BLICS & FLXTURES 2.00 00200 CAP FEL COSTS - MUNCAL EQUIPMENT 3.00 00300 LMPLOYEE BENEFITS 3.00 00300 LTATSERVICE 3.00 00300 LMPLOYEE BENEFITS 3.00 01300 CHAREACY 3.00 0300 CHAREACY 3.00 03000 CHAREACY 3.00 03000 CHAREACY 3.00 03000 CHAREACY 3.00 03000 CHAREACY 3.00 00			4.00	5.00	6.00	7.00	8.00	
2.00 00200 [CAP REL COSTS - MOVABLE FOULPMENT 4.00 00400 ADM MISTRATIVE & GENERAL 2.149,718 5.00 00500 [PLATOPERTITION, MAINT & REPAIRS 5.00 00500 [PLATOPERTITION, MAINT & REPAIRS 5.00 00500 [PLATOPERTITION, MAINT & REPAIRS 5.00 00500 [PLATOPERTITION] 6.00 00600 [PLATOPERTITION] 6.00 00600 [PLATATOPERTITION] 6.00 00600 [PLATATOPERTITION] 1.00 01000 [PLATATALSERVICE & SUPPLY 1.00 01000 [NEITIALSERVICE & SUPPLY 1.00 01000 [NEITIALSERVICE COST CENTERS 3.00 01000 [SCI LL SERVICE COST CENTERS 3.00 01000 [SCI LL SERVICE COST CENTERS 3.00 01000 [SCI LL SERVICE COST CENTERS 3.00 01000 [SCI LLE SERVICE COST CENTERS 3.00 01000 [SCI LLE SERVICE COST CENTERS 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00		1		1	1		1 1 00
7. 00 00700 HOUSEKEPTING 55, 133 10, 336 0 361, 383 9. 00 00900 NURSI NG ADMINISTRATION 1115, 346 17, 117 0 8, 175 9. 00 001100 PHARMACY 0 0 0 0 0 01100 DENTRAL SERVICES & SUPPLY 16, 818 0 0 0 0 01100 DENTRAL SERVICE 38, 083 3, 529 0 1, 686 0 01300 SOCIAL SERVICE COST CENTERS 0 0 0 0 0 01400 MIRSI NG ADALLED HEALTH EQUATION 0 0 0 0 0 003000 SKI LED MURSI NG FACILITY 1, 247, 606 574, 470 366, 447 274, 370 1, 726, 57 30. 00 03000 UNRESI NG FACILITY 1, 247, 606 574, 470 0 0 0 30. 00 03000 UNRESI NG FACILITY 1, 247, 606 574, 470 0 0 0 0 30. 00 03000 UNRESI NG FACILITY 1, 247, 606 0 0 0 0 0 0 <	2.00 3.00 4.00 5.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	124, 022			7		1.00 2.00 3.00 4.00 5.00 6.00
9 00 00000 NURSI NG ADMINISTRATION 115, 346 17, 117 0 0 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0								7.00
10.00 01000 CENTRAL_SERVICES SUPPLY 16.818 0 0 0 11.00 01000 MEDICAL_RECORDS & LIBRARY 17.630 20.319 0 9.704 13.00 01300 MEDICAL_RECORDS & LIBRARY 17.630 20.319 0 9.704 13.00 01300 NURS AND ALLED HEALTH EDUCATION 0 0 0 0 10.00 01400 NURS NG AND ALLED HEALTH EDUCATION 0 0 0 0 10.00 03000 SKILLED NIKS NG FACILITY 1.247.806 574.470 3.68.447 274.370 1.726.57 31.00 03300 ICF/II 0 0 0 0 0 0 32.00 03300 ICF/II NERAPY 7.484 0 0 0 0 0 43.00 04200 INTRAVENUS THERAPY 7.632 19.663 9.931 4.322 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	8.00						1, 726, 573	8.00
11.00 01100 PHARMACY 0 0 0 0 12.00 01200 BEDICAL SCROPS & LIBRARY 17, 630 20, 319 0 9, 704 13.00 01300 SOCIAL SERVICE 38, 083 3, 529 0 1, 666 14.00 140, 001400 NURSING KAD ALLED HALTH EDUCATION 31, 220 0 0 0 15.00 01500 ACTI VIT IES SCRULLTY 1, 247, 806 574, 470 3668, 447 274, 370 1, 726, 57 30.00 03300 DIRSING FACILITY 1, 247, 806 574, 470 3668, 447 274, 370 1, 726, 57 31.00 03300 DIRSING FACULITY 1, 247, 806 0 <td>9.00</td> <td>00900 NURSI NG ADMI NI STRATI ON</td> <td>115, 346</td> <td>17, 117</td> <td>(</td> <td>0 8, 175</td> <td>0</td> <td>9.00</td>	9.00	00900 NURSI NG ADMI NI STRATI ON	115, 346	17, 117	(0 8, 175	0	9.00
12:00 01200 MEDICAL RECORDS & LIBRARY 17,630 20,319 0 9,704 13:00 01300 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 10:00 01400 NURSING AND ALLIED HEALTH EDUCATION 31,220 0 0 0 10:00 03000 NURSING FACILITY 1,247,806 574,470 368,447 274,370 1,726,57 31:00 03000 NURSING FACILITY 1,247,806 574,470 368,447 274,370 1,726,57 31:00 03300 OTHER LONG TEEM CARE 0 0 0 0 0 0 33:00 03300 OTHER LONG TEEM CARE 0 <td></td> <td></td> <td>16, 818</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>10.00</td>			16, 818			0 0	0	10.00
13.00 01300 Social Sectial SERVICE 38,083 3,5.29 0 1,666 14.00 01400 UNSING AND ALLIED HEALTH EDUCATION 31,220 0 0 0 15.00 01500 ACTIVITES SERVICE COST CENTERS			-	-		-	0	11.00
14.00 01400 VUESING AND ALLIED HEALTH EDUCATION 0 0 0 0 15.00 01500 CENTERS 31.220 0 0 0 10.00 CARLED NUESING FACILITY 1.247.806 574.470 368.447 274.370 1.726.57 31.00 O3000 VIESING FACILITY 1.247.806 574.470 368.447 274.370 1.726.57 32.00 O3200 (1cF/1 ID 0 0 0 0 0 0 0 00 O3300 (1cF/1 ID 0						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	12.00
15.00 01500 ACTI VIT LES 31, 220 0 0 INPARTIENT ROUTINE SERVICE COST CENTERS							0	13.00
INPATIENT ROUTINE SERVICE COST CENTERS Image Structure Image Structure Image Structure 31 00 03100 NURSING FACLLITY 1,247,806 574,470 368,447 274,370 1,726,57 31 00 03300 Inter LONG TERM CARE 0 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td>0</td><td>14.00 15.00</td></td<>			-			-	0	14.00 15.00
30:00 03000 SKULLED NURSING FACILITY 1, 247, 806 574, 470 368, 447 274, 370 1, 726, 57 31:00 0300 INURSING FACILITY 0	15.00		51,220	0	<u>/</u>	0	0	15.00
131.00 OX300 INC FACILITY 0 0 0 33.00 03300 IFFR LONG TERN CARE 0 0 0 ANGULLARY SERVICE COST CENTERS	30 00		1 247 806	574 470	368 44	7 274 370	1 726 573	30.00
32.00 03200 1CF./I D 0 0 0 33.00 03300 OTHER LONG TERM CARE 0 0 0 40.00 04000 RADI LLARY SERVICE COST CENTERS 0 0 0 40.00 04000 RADI LLARY SERVICE COST CENTERS 0 0 0 41.00 LABORATORY 7,484 0 0 0 30.01 04300 OX4000 FINER LARAY 3,988 0 0 0 30.01 04400 PHYSICAL THERAPY 57,632 19,663 0 9,391 45.00 04600 SPEECH PATHOLOGY 27,638 0 0 0 0 46.00 04600 RED CALSUPPLIES CHARGED TO PATIENTS 2,441 5,672 0 2,709 49.00 04000 DRUGS CHARGED TO PATIENTS 2,441 5,672 0 0 0 51.00 05000 DENTAL CARE - TITLE XI X ONLY 0 0 0 0 0 0 62.00 05000 DENTAL CARE - TITLE XI X ONLY 0 0							0	31.00
ANCILLARY SERVICE COST CENTERS	32.00		0	C) (0 0	0	32.00
40.00 04000 RADIOLOGY 2,074 0 0 41.00 04100 LABORATORY 7,484 0 0 42.00 04200 INTRAVENOUS THERAPY 3,988 0 0 0 43.00 04300 DVGCEN INTRAVENOUS THERAPY 3,988 0 0 0 44.00 04400 PHYSICAL THERAPY 3,772 0 0 0 0 44.00 04400 PHYSICAL THERAPY 57,653 0 0 0 0 45.00 04500 SPECET PATHOLOGY 27,653 0 0 0 0 0 46.00 04500 BEDICTROCARDIOLOCY 27,673 0 <td< td=""><td>33.00</td><td>03300 OTHER LONG TERM CARE</td><td>0</td><td>C</td><td>) (</td><td>0 0</td><td>0</td><td>33.00</td></td<>	33.00	03300 OTHER LONG TERM CARE	0	C) (0 0	0	33.00
11.00 VABORATORY 7,484 0 0 42.00 04200 INTRAVENOUS THERAPY 3,988 0 0 42.00 04300 OXYGEN (INHALATION) THERAPY 3,772 0 0 0 44.00 04400 PMSICAL THERAPY 57,632 19,663 0,9391 45.00 04600 SCECH PATHOLOGY 27,638 0 0 0 46.00 04600 SECH PATHOLOGY 27,638 0 0 0 0 47.00 04700 LECTROCABDIOLOGY 2,709 2,709 2,709 2,709 49.00 OLGOG CLINTC KARE - TITLE KIX ONLY 0 0 0 0 0 0 05000 DENTAL CASE - TO EXTLEX X ONLY 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
42.00 INTRAVENOUS THERAPY 3,988 0 0 0 43.00 04300 OXYGEN (I MHALATION) THERAPY 3,772 0 0 0 44.00 04400 PHYSICAL THERAPY 68,659 9,050 0 4,322 45.00 04500 COUPATIONAL THERAPY 68,659 9,050 0 4,322 46.00 04400 SPECH PATHOLOGY 27,638 0 0 0 47.00 04700 ELCTROCARDIOLOGY 27,638 0 0 0 48.00 04900 PRUCS CHARGED TO PATIENTS 2,6418 5,672 0 2,709 49.00 04900 PRUCS CHARGED TO PATIENTS 26,618 2,647 0 1,264 50.00 05000 DIPORT SURFACES 761 0 0 0 51.00 05100 SUPPORT SURFACES 761 0 0 0 63.00 63000 OHER ARCI LLARY SERVICE COST CENTERS 0 0 0 0							0	40.00
43.00 04300 DVYGEN (1NHALATION) THERAPY 3, 772 0 0 0 44.00 04400 PHYSICAL THERAPY 57, 632 19, 663 0 9, 391 45.00 04600 DCUPATIONAL THERAPY 68, 659 9, 050 0 4, 222 46.00 04600 SECCH PATHOLOGY 27, 638 0 0 0 47.00 04700 ELCETROCARDI OLOGY 27, 638 0 0 0 47.00 04000 RUGARGED TO PATI ENTS 2, 441 5, 672 0 2, 709 49.00 04900 DRUGS CHARGED TO PATI ENTS 2, 641 2, 647 0 1, 264 50.00 SUPPORT SURFACES 761 0 0 0 0 51.00 05200 DTHAL CARE - TI TLE XI X ONLY 0 0 0 0 60.00 60000 CLINIC 0 0 0 0 0 61.00 05200 DTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 62.00 66300 DTHER ACHALTH AGENCY COST 0						0 0	0	41.00
44.00 D4400 PHYSI CAT THERAPY 57, 632 19, 663 0 9, 391 45.00 04500 OCCUPATI ONAL THERAPY 68, 659 9, 050 0 4, 322 46.00 04000 SPEECH PATHOLOCY 27, 638 0 0 0 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 48.00 04900 ROUGS CHARGED TO PATIENTS 2, 441 5, 672 0 2, 709 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51.00 05100 SUPPORT SURFACES 761 0 0 0 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 60.00 06000 RURAL HEALTH CLINIC 0 0 0 0 0 63.00 06300 OTHER OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 71.00 OTOOL MBULANCE 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>42.00</td>							0	42.00
45.00 04500 OCCUPATIONAL THERAPY 68.659 9,050 0 4.322 46.00 04600 SPECH PATHOLOGY 27,638 0 0 0 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2,441 5,672 0 2,709 49.00 04900 DRUGS CHARGED TO PATIENTS 26,618 2,647 0 1,264 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0100 05200 OTHER ANCILLARY SERVICE COST CENTERS 761 0 0 0 0 00100 0000 0 0 0 0 0 0 0 000 06000 CLINIC 0 0 0 0 0 0 0 000 06000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-		0 301	0	43.00
46.00 04600 SPECH PATHOLOGY 27,633 0 0 47.00 04700 ELECTROCARDIOLOGY 0 0 0 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2,441 5,672 2,709 49.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2,641 5,672 0 2,709 49.00 05000 DENTAL CARE - TILE XIX ONLY 0 0 0 0 0 51.00 DSPORT SURFACES 761 0 0 0 0 0 0017047 DIFRA ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 00107147 NIT SERVICE COST CENTERS 0 0 0 0 0 0010747 DIFRA ANCILLARY SERVICE COST CENTER 0 0 0 0 0 01000 OFILER ALHEALTH CLINIC 0 0 0 0 0 0 0200 FOHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0						.,	0	45.00
47.00 04700 04700 0 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,441 5,672 0 2,709 49.00 04900 DRUSC CHARGED TO PATIENTS 2,6.618 2,647 0 1,264 50.00 DS000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51.00 OS2000 OHERA ANCILLARY SERVICE COST CENTERS 0 0 0 0 00.00 05200 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 00.01 OS2000 OHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 00.00 06300 OHER OUTPATIENT SERVICE COST CENTER 0							0	46.00
49.00 04900 DRUGS CHARGED TO PATLENTS 26,618 2,647 0 1,264 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 0 0 0 0 51.00 05100 SUPPORT SURFACES 761 0 0 0 60.00 06600 CLINIC 0 0 0 0 0 61.00 06600 CLINIC 0 0 0 0 0 61.00 06600 CHAR HEALTH CLINIC 0 0 0 0 63.00 06300 OTHER NUTPATIENT SERVICE COST CENTER 0 0 0 0 70.00 7000 MBURSABLE COST CENTERS 0 0 0 0 0 71.00 07100 MBURSABLE COST 0 <t< td=""><td>47.00</td><td>04700 ELECTROCARDI OLOGY</td><td>0</td><td>0</td><td>) (</td><td>0 0</td><td>0</td><td>47.00</td></t<>	47.00	04700 ELECTROCARDI OLOGY	0	0) (0 0	0	47.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51.00 05100 SUPPORT SURFACES 761 0 0 0 52.00 DESCOLOTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 63.00 06200 FHE OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 63.00 06200 FHE OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 70.00 07000 HMBE HEALTH AGENCY COST 0 0 0 0 0 70.00 07200 CORF 0 0 0 0 0 0 73.00 07300 CMBULANCE 0 0 0 0 0 0 74.00 07400 OHER REI MBURSABLE COST 0 0 0 0 0 75.00 08200 UTLI ZATION REVIEW 0 0 0 0	48.00		2, 441	5, 672	2 (2, 709	0	48.00
51.00 05100 SUPPORT SURFACES 761 0 0 0 60.00 05200 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 60.00 06000 CLINIC 0 0 0 0 0 60.00 06000 RURAL HEALTH CLINIC 0 0 0 0 0 62.00 60300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 70.00 7000 HOME HEALTH AGENCY COST 0 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 0 73.00 07400 OTHER REI MBURSABLE COST 0 0 0 0 0 74.00 07400 OTHER REI MBURSABLE COST 0 0 0 0 0 75.00 08200 UTH LI RATI ON REVI EW </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>49.00</td>							0	49.00
52.00 OS200 OTHER ANCI LLARY SERVICE COST CENTERS O O O 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0000 CINIC 0 0 0 0 0 61.00 O6000 CLINIC 0 0 0 0 0 63.00 OB200 FOHE 0 0 0 0 63.00 OB200 FOHE OUTPATIENT SERVICE COST CENTERS 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 70.00 07000 HOME HEALTH AGENCY COST 0			-			5	0	50.00
OUTPATIENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>1</td><td></td><td></td><td>-</td><td>0</td><td>51.00 52.00</td></t<>			1			-	0	51.00 52.00
60.00 06000 CLINIC 0 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 62.00 06200 FOHC 0 0 0 0 0 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 71.00 07100 ABULANCE 0 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 0 0 73.00 07300 CMHC 0	52.00		U	0	<u>/</u>	0	0	52.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 62.00 06200 FOHC 0 0 0 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 70.00 O7000 HOME HEALTH AGENCY COST 0 0 0 0 0 71.00 O7100 AMBULANCE 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 0 73.00 O7300 CMHC 0 0 0 0 0 74.00 O7400 OTHER REI MBURSABLE COST 0 0 0 0 0 75.00 O7300 CMHC 0	60 00		0	0		0	0	60.00
62.00 06200 FOHC 0 0 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTERS 0 0 0 00 0THER REIMBURSABLE COST CENTERS 0 0 0 0 07000 HOME HEALTH AGENCY COST 0 0 0 0 70.00 O7000 HOME HEALTH AGENCY COST 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 0 74.00 07400 OTHER REI MBURSABLE COST 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMI UMS & PAID LOSSES 0 0 0 0 81.00 08100 INTEREST EXPENSE 0 0 0 0 0 82.00 08200 UTI LIZATI ON REVIEW 0 0 0 0 0 0 0 0 0 0 0 0 0 0							0	•
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 0 73.00 07300 CMHC 0 0 0 0 0 74.00 07400 OTHER REI MBURSABLE COST 0 0 0 0 0 74.00 07400 OTHER REI MBURSABLE COST 0	62.00							62.00
70.00 07000 HOME HEALTH AGENCY COST 0<	63.00		0	0) (0 0	0	63.00
71.00 07100 AMBULANCE 0 0 0 72.00 07200 CORF 0 0 0 73.00 07300 CMHC 0 0 0 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 SPECIAL PURPOSE COST CENTERS 0 0 0 0 SPECIAL PURPOSE COST CENTERS 0 0 0 0 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 0 0 0 81.00 08100 INTEREST EXPENSE 0 0 0 0 82.00 08300 HOSPI CE 0 0 0 0 83.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 0 84.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 0 90.00 SUBTOTALS (sum of 1 i nes 1-84) 2, 148, 414 789, 681 368, 447 361, 383 1, 726, 57 90.00 OP100 BARBER AND BEAUTY SHOP 1, 304 0 0 0 <			I		1			
72.00 07200 CORF 0 0 0 73.00 07300 CMHC 0 0 0 0 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMI UMS & PAI D LOSSES 0 0 0 0 81.00 08100 INTEREST EXPENSE 0 0 0 0 0 82.00 08200 UTI LI ZATI ON REVI EW 0 0 0 0 0 83.00 08300 HOSPI CE 0 0 0 0 0 84.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 2,148,414 789,681 368,447 361,383 1,726,57 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 1,304 0 0 0 91.00 09200 PHYSI CI ANS PRI			0	0		5		70.00
73.00 07300 CMHC 0 0 0 0 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 0 0 0 81.00 08100 INTEREST EXPENSE 0 0 0 82.00 08200 UTI LI ZATI ON REVI EW 0 0 0 83.00 08300 HOSPI CE 0 0 0 0 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 2, 148, 414 789, 681 368, 447 361, 383 1, 726, 57 NORREI MBURSABLE COST CENTERS 0 0 0 0 0 0 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 1, 304 0 0 0 0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td>0</td><td>71.00</td></t<>			0	0			0	71.00
74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 SPECIAL PURPOSE COST CENTERS			0	0			0	
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81.00 08100 INTEREST EXPENSE 82.00 08200 UTI LI ZATI ON REVI EW 83.00 08300 HOSPI CE 00 08300 OTHER SPECIAL PURPOSE COST CENTERS 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 00 00 0 00 00 0 00 00 0 00 00 0 00 00 0 00 0 0 00 0 0 00 0 0 00 0 0 00 0 0 00 0 0 00 0 0 00 0 0 <td></td> <td></td> <td>0</td> <td>-</td> <td></td> <td>-</td> <td>0</td> <td></td>			0	-		-	0	
81.00 08100 INTEREST EXPENSE 0 0 0 82.00 08200 UTI LI ZATI ON REVIEW 0 0 0 83.00 08300 HOSPI CE 0 0 0 84.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 2,148,414 789,681 368,447 361,383 1,726,57 NONREI MBURSABLE COST CENTERS 90.00 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 91.00 O9100 BARBER AND BEAUTY SHOP 1,304 0 0 0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 93.00 09300 NONPAI D WORKERS 0 0 0 0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0								
82.00 08200 UTILIZATION REVIEW 0 0 0 83.00 08300 HOSPICE 0 0 0 0 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 2,148,414 789,681 368,447 361,383 1,726,57 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 1,304 0 0 0 0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 93.00 09300 NONPAID WORKERS 0	80.00							80.00
83.00 08300 HOSPICE 0		08100 INTEREST EXPENSE						81.00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 2,148,414 789,681 368,447 361,383 1,726,57 NONREI MBURSABLE COST CENTERS 90.00 O9100 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 1,304 0 0 0 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 93.00 09300 NONPAI D WORKERS 0 0 0 0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0								82.00
89.00 SUBTOTALS (sum of lines 1-84) 2,148,414 789,681 368,447 361,383 1,726,57 NORREI MBURSABLE COST CENTERS			0	0		0 0	0	83.00
NONREI MBURSABLE COST CENTERS 90. 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 91. 00 09100 BARBER AND BEAUTY SHOP 1, 304 0 0 0 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 93. 00 09300 NONPAI D WORKERS 0 0 0 0 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0			0					84.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 1, 304 0 0 0 92.00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 0 0 93.00 09300 NONPAI D WORKERS 0 0 0 0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0	89.00		2, 148, 414	/89, 681	368, 44	361, 383	1, 726, 573	89.00
91.00 09100 BARBER AND BEAUTY SHOP 1,304 0 0 0 92.00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 0 0 93.00 09300 NONPAI D WORKERS 0 0 0 0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0	90 00			0			0	90.00
92.00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 0 0 93.00 09300 NONPAI D WORKERS 0 0 0 0 0 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0			-			-	0	91.00
93. 00 09300 NONPAI D WORKERS 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>92.00</td>			0	0		0 0	0	92.00
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0			0	0		o o	0	93.00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0			0	C) (0 0	0	94.00
			0	C		0 0	0	95.00
		3	0	C		0 0	0	98.00
			0	0			0	99.00
100. 00 TOTAL 2, 149, 718 789, 681 368, 447 361, 383 1, 726, 57	100.00	I I I I I I I I I I I I I I I I I I I	2, 149, 718	/89, 681	368, 44	361, 383	1, 726, 573	1100.00

Heal th	Financial Systems	MAPLE GLEN	I CENTER			In Lie	u of Form CMS-2	2540-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315328		riod: om 01/01/2022 12/31/2022	Worksheet B Part I Date/Time Pre 5/17/2023 2:3	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY		MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	<u> </u>
		9.00	10.00	11.00		12.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1	_			1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY							2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	759, 731						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	107, 085					10.00
11.00	01100 PHARMACY	0	0		0			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0	142, 279	247 701	12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	247, 701 0	13.00 14.00
14.00	01500 ACTIVITIES	0	0		0	0	0	14.00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u>ч</u>	0	1	0	0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	759, 731	107, 085		0	124, 683	247, 701	30.00
31.00	03100 NURSING FACILITY	0	C		0	0	0	31.00
32.00	03200 CF/I D	0	0	1	0	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	0	0		0	140	0	40.00
40.00	04000 KADI OLOGI 04100 LABORATORY	0	0	1	0	714	0	40.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	148	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C)	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	C		0	5, 442	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0	6, 949	0	45.00
46.00		0	0		0	2, 948	0	46.00
47.00 48.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	47.00 48.00
48.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	1, 245	0	48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	Ő		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	C)	0	10	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS			1	-			
60.00	06000 CLINIC	0	0	1	0	0	0	60.00
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	C		0	0	0	61.00 62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0	0	0	63.00
00.00	OTHER REIMBURSABLE COST CENTERS				0			
70.00	07000 HOME HEALTH AGENCY COST	0	C)	0	0	0	70.00
71.00	07100 AMBULANCE	0	0		0	0	Ŭ	71.00
72.00	07200 CORF	0	0		0	0	0	
73.00		0	0		0	0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	C	1	0	0	0	74.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							80. 00 81. 00
82.00	08200 UTI LI ZATI ON REVI EW							82.00
83.00	08300 HOSPI CE	0	C		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) NONREIMBURSABLE COST CENTERS	759, 731	107, 085		0	142, 279	247, 701	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	0	91.00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	Ő	0	92.00
93.00	09300 NONPAI D WORKERS	0	C		0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	C		0	0	0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0	0	95.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	0		0	_	0	98.00 99.00
99.00 100.00	0	759, 731	107, 085		0	0 142, 279	-	
100.00		107,101	107,000	1	9	142, 217	247,701	1.00.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	MAPLE GLE			Period: From 01/01/2022	u of Form CMS- Worksheet B Part I	
					o 12/31/2022	Date/Time Pre 5/17/2023 2:3	epared: 88 pm
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	_
1.00 2.00 3.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						1.00 2.00 3.00
4.00 5.00	00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS						4.00 5.00
6.00 7.00 8.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY						6.00 7.00 8.00
9.00 10.00 11.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY						9.00 10.00 11.00
14.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	100.70				12.00 13.00 14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	198, 784	k			15.00
31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID	000000000000000000000000000000000000000			0 0	12, 326, 957 0 0	31.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C		0 0	0	33.00
41.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0 0 0			3 0	13, 346 48, 368 25, 538	41.00
	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY	0		1017 100	3 0	24, 017 401, 453 457, 490	44.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0) 178, 924) (4 O O O	178, 924 0	46.00 47.00
50.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0			0 0	23, 925 174, 641 0	49.00 50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATI ENT SERVICE COST CENTERS	000	C			4, 856 0	
50.00 51.00 52.00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0				0 0	
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	-			0	63.00
71.00 72.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07200 CORF	0 0 0			0 0	0 0 0	71.00
	07300 CMHC 07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	C			0	
81.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						80.00 81.00 82.00
83.00 84.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0) (0 0	0 0	83.00 84.00
	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	198, 784) () 0	<u>13, 679, 515</u> 0	90.00
92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0 0 0) 8, 301) (8, 301 0 0	92.00
94.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0			0 0	0 0 0	94.00 95.00
98.00 99.00 100.00	Negative Cost Centers		C 198, 784) (0 0	0 0 13, 687, 816	99.00

	Financial Systems TION OF CAPITAL RELATED COSTS	MAPLE GLEN			eriod: rom 01/01/2022	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/17/2023 2:3	pared:
			CAPI TAL REI	LATED COSTS		0, 11, 2020 210	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FI XTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		0	1.00	2.00	2A	3.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	50, 442			52, 119	
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	152, 960 124, 048			4, 816 1, 002	1
5.00 6.00	00600 LAUNDRY & LINEN SERVICE	0	50, 724			1,002	1
7.00	00700 HOUSEKEEPING	0	23, 108			0	
8.00	00800 DI ETARY	0	232, 935	7, 746	240, 681	0	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	38, 268			4, 708	
	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	551	1
	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	45, 426	0 1, 511	46, 937	0 414	1
	01300 SOCIAL SERVICE	0	7, 890			1, 691	1
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			0	
15.00	01500 ACTI VI TI ES	0	0	0	0	1, 408	15.00
20.00			1 204 227	40.705	1 227 022	27 520	
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	1, 284, 327 0	42, 705 0		37, 529 0	1
	03200 I CF/I I D	0	0	0	-	0	1
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	ANCI LLARY SERVICE COST CENTERS			-			
	04000 RADI OLOGY 04100 LABORATORY	0	0			0	1
	04200 I NTRAVENOUS THERAPY	0	0	3		0	
	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	1
	04400 PHYSI CAL THERAPY	0	43, 961	1, 462	45, 423	0	44.00
	04500 OCCUPATI ONAL THERAPY	0	20, 233			0	
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	0	-	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 681		-	0	1
	04900 DRUGS CHARGED TO PATIENTS	0	5, 918			0	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	-	-	0	50.00
	05100 SUPPORT SURFACES	0	0	0		0	
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
60.00	06000 CLINIC	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
	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	0	
	07200 CORF	0	0	0	0	0	1
		0	0	0	0	0	
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	74.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW						82.00
		0	0	0	0	0	
84.00 89.00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0	0 2, 092, 921	69, 594	0 2, 162, 515	0 52, 119	1
57.00	NONREI MBURSABLE COST CENTERS	0	2, 072, 721	07, 394	2, 102, 515	52, 119	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	1
	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0		0	0	
	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	1
			0	I		0	
98.00	Cross Foot Adjustments				0		98.00
	Negative Cost Centers	0	0 2, 092, 921	0 69, 594	0 0 2, 162, 515	0	1

	Financial Systems TION OF CAPITAL RELATED COSTS	MAPLE GLEN		No.: 315328 P	In Lie eriod:	u of Form CMS-2 Worksheet B	2540-10
ALLUUA	TION OF CAPITAL RELATED CUSTS		FIOVIDEI	F	rom 01/01/2022 o 12/31/2022	Part II Date/Time Pre 5/17/2023 2:33	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT & REPAI RS	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1		1			1.00
2.00 3.00 4.00 5.00 6.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	162, 862 9, 396 4, 114	138, 571 3, 981	60, 506			2.00 3.00 4.00 5.00 6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY	4, 177 18, 711	1, 814 18, 283			281, 788	7.00 8.00
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	8, 738	3, 004		4, 113	201, 700	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	1, 274	3, 004 0		0,0	0	10.00
11.00	01100 PHARMACY	0	0		0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	1, 336	3, 565	0	802	0	12.00
13.00	01300 SOCIAL SERVICE	2, 885	619	0	139	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14.00
15.00	01500 ACTI VI TI ES	2, 365	0	0 0	0	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	04 522	100 909	40 E04	22, 676	201 700	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	94, 533 0	100, 808 0			281, 788 0	30.00 31.00
32.00	03200 I CF/I I D	0	0			0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0			0	33.00
	ANCI LLARY SERVICE COST CENTERS	-	-	-	-		
40.00	04000 RADI OLOGY	157	0	0 0	0	0	40.00
41.00	04100 LABORATORY	567	0			0	41.00
42.00	04200 I NTRAVENOUS THERAPY	302	0	-	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	286	0		0	0	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	4, 366 5, 202	3, 450 1, 588		776 357	0	44.00 45.00
45.00	04600 SPEECH PATHOLOGY	2,094	1, 566			0	45.00
47.00	04700 ELECTROCARDI OLOGY	2,0,1	0		0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	185	995	0	224	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	2, 017	464	0	104	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51.00	05100 SUPPORT SURFACES	58	0		0	0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	52.00
60.00	06000 CLINIC	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0			0	61.00
62.00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS		0		0		
	07000 HOME HEALTH AGENCY COST	0	0		0	0	70.00
71.00 72.00	07100 AMBULANCE 07200 CORF	0	0		0	0	71.00 72.00
73.00	07300 CMHC	0	0	0	0	0	73.00
		0	0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW 08300 HOSPICE		~	-		^	82.00
83.00 84.00	08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	83.00 84.00
89.00	SUBTOTALS (sum of lines 1-84)	162, 763	138, 571	60, 506	29, 867	281, 788	89.00
09,00	NONREI MBURSABLE COST CENTERS				2.,001	201,100	
69.00		0	0	0	0	0	90.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0	0	91.00
90. 00 91. 00	09100 BARBER AND BEAUTY SHOP	99	0	0	9		
90. 00 91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CI ANS PRI VATE OFFI CES		0 0	0	0	0	92.00
90. 00 91. 00 92. 00 93. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0 0 0		0	0 0	92. 00 93. 00
90.00 91.00 92.00 93.00 94.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY				000000000000000000000000000000000000000	0 0 0	92.00 93.00 94.00
90.00 91.00 92.00 93.00 94.00 95.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS		0 0 0 0 0			0 0 0 0	92.00 93.00 94.00 95.00
90.00 91.00 92.00 93.00 94.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY		0 0 0 0 0 0 0			0 0 0	92.00 93.00 94.00

Heal th	Financial Systems	MAPLE GLEN	I CENTER			In Lie	u of Form CMS-2	2540-10
	TION OF CAPITAL RELATED COSTS			No.: 315328		riod: om 01/01/2022	Worksheet B	
					To	12/31/2022	Part II Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL	5/17/2023 2: 3 SOCI AL SERVI CE	8 pm
	oust center bescription	ADMI NI STRATI ON	SERVICES &			RECORDS &	SOUTHE SERVICE	
		9.00	SUPPLY 10.00	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 & FIXTURES							1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT							2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL							3.00 4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS							5.00
6.00	00600 LAUNDRY & LINEN SERVICE							6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY							7.00 8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	56, 667						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	1, 825		~			10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0		0	53, 054		11. 00 12. 00
13.00	01300 SOCI AL SERVICE	0	0		0	00,001	13, 486	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	1	0	0	0	15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	56, 667	1, 825		0	46, 494	13, 486	30.00
31.00	03100 NURSING FACILITY	0	0		0	0	0	31.00
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0		0 0	0 0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	1	0	0	0	33.00
40.00	04000 RADI OLOGY	0	0		0	52	0	40.00
41.00	04100 LABORATORY	0	0		0	266	0	41.00
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0		0	55 0	0	42.00 43.00
44.00	04400 PHYSI CAL THERAPY	0	0)	0	2, 029	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0		0	2, 591	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0		0	1, 099 0	0	46.00 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	464	0	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0	0	0	50. 00 51. 00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS	1 -1		1	-			
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0	0	0	60. 00 61. 00
62.00	06200 FQHC	0	0		Ŭ	0	0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	0	70.00
	07100 AMBULANCE	0	0		0	0		71.00
72.00	07200 CORF	0	0		0	0	0	72.00
	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0		0 0	0	0	73.00 74.00
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	1	0	0	0	74.00
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80.00
81.00	08100 INTEREST EXPENSE							81.00
82.00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	0		0	0	0	82.00 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)	56, 667	1, 825		0	53, 054	13, 486	89.00
90.00	NONREIMBURSABLE COST CENTERS 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 PHYSI CLANS PRI VATE OFFICES	0	0		0	0	0	92.00
93.00 94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0		0	0	0	93.00 94.00
94.00 95.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0	0	94.00 95.00
98.00	Cross Foot Adjustments	0	0		0			98.00
99.00 100.00	Negative Cost Centers TOTAL	0 56, 667	0 1, 825		0 0	0 53, 054	0 13, 486	99.00 100.00
100.00		00,007	1, 020	1	U	55, 054	13, 400	100.00

	Financial Systems TION OF CAPITAL RELATED COSTS	MAPLE GLEI			Peri od:	u of Form CMS- Worksheet B	
					From 01/01/2022	Part II	nored.
					To 12/31/2022	Date/Time Pre 5/17/2023 2:3	
			OTHER GENERAL				
	Cost Center Description	NURSI NG AND	SERVI CE ACTI VI TI ES	Subtotal	Post Step-Down	Total	
	cost center bescription	ALLI ED HEALTH	ACTIVITIES	Subtotal	Adjustments	Total	
		EDUCATI ON					
		14.00	15.00	16.00	17.00	18.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - BEDGS & FIXTORES						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPING						7.00
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	3, 773	š			15.00
30.00	03000 SKILLED NURSING FACILITY	0	3, 773	2, 047, 11	7 0	2, 047, 117	30.00
31.00	03100 NURSING FACILITY	0			0 0	0	
32.00	03200 CF/I D	0	C		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	C)	0 0	0	33.00
10.00	ANCI LLARY SERVICE COST CENTERS						1 40 00
40.00	04000 RADI OLOGY 04100 LABORATORY	0				209 833	
41.00	04200 I NTRAVENOUS THERAPY	0			-	357	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C C			286	
44.00	04400 PHYSI CAL THERAPY	0	C	56, 04	4 0	56, 044	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	C	30, 64		30, 644	
46.00		0	C			3, 193	
47.00 48.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0 7 0	0 14, 507	
49.00	04900 DRUGS CHARGED TO PATIENTS	0				9, 164	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C		0 0	0	1
51.00	05100 SUPPORT SURFACES	0			2 0	62	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	C)	0 0	0	52.00
(0.00	OUTPATI ENT SERVICE COST CENTERS	0	C	1	0 0	0	
60.00 61.00	06100 RURAL HEALTH CLINIC	0			0 0	0	
62.00	06200 FQHC				0	0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C)	0 0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	1		1	-		
70.00	07000 HOME HEALTH AGENCY COST	0			0 0	0	
71.00 72.00	07100 AMBULANCE 07200 CORF	0			0 0 0 0	0	
72.00	07300 CMHC	0			0 0	0	
74.00	07400 OTHER REIMBURSABLE COST	0			0 0	0	
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00 83.00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	l c		0 0	0	82.00 83.00
83.00	08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST CENTERS	0		1	0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0			-	2, 162, 416	
	NONREIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	· · ·				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	C		9 0	99	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0		1	0 0 0 0	0	
93.00 94.00	09300 NONPATE WORKERS				0 0	0	
		0			0 0	0	
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0		'		0	1 23.00
95. 00 98. 00	Cross Foot Adjustments	0	C		0 0	0	98.00
95.00	Cross Foot Adjustments Negative Cost Centers	0	C C 3, 773		0 0 0 0		98.00 99.00

51 A	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2022	Worksheet B-1	
					o 12/31/2022	Date/Time Pre 5/17/2023 2:3	
		CAPITAL REI	ATED COSTS				
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS		1	1			
00	00100 CAP REL COSTS - BLDGS & FIXTURES	37, 135					1
00 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	895	37, 135 895				2
00	00400 ADMI NI STRATI VE & GENERAL	2, 714				11, 538, 098	4
00	00500 PLANT OPERATION, MAINT. & REPAIRS	2, 201	2, 201			665, 659	5
00	00600 LAUNDRY & LINEN SERVICE	900			-	291, 456	
00	00700 HOUSEKEEPI NG	410				295, 914	7
00		4, 133				1, 325, 635	8
00 . 00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	679 0				619, 093 90, 267	
. 00	01100 PHARMACY	0	0	33, 23		0,207	11
. 00	01200 MEDI CAL RECORDS & LI BRARY	806	806	41, 523	3 0	94, 626	
. 00	01300 SOCIAL SERVICE	140				204, 403	13
. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	-		-	0	14
. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	141, 195	5 O	167, 564	15
. 00	03000 SKILLED NURSING FACILITY	22, 788	22, 788	3, 762, 807	0	6, 697, 307	30
. 00	03100 NURSING FACILITY	0				0	31
. 00	03200 CF/I D	0	-			0	32
. 00	03300 OTHER LONG TERM CARE	0	0	(0 0	0	33
. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	0	0	11, 132	40
. 00	04100 LABORATORY	0	0			40, 170	
. 00	04200 I NTRAVENOUS THERAPY	0	0		0	21, 402	
. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0 0	20, 245	43
. 00	04400 PHYSI CAL THERAPY	780			0	309, 325	
. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	359 0			-	368, 510 148, 338	
. 00	04700 ELECTROCARDI OLOGY	0				140, 338	40
. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	225	-		0	13, 103	
. 00	04900 DRUGS CHARGED TO PATIENTS	105	105	0	0 0	142, 867	49
. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	-			0	50
. 00	05100 SUPPORT SURFACES	0	-		-	4, 085	
. 00	05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0	(0 0	0	52
. 00	06000 CLINIC	0	0	0	0	0	60
. 00	06100 RURAL HEALTH CLINIC	0	0	(0	61
. 00	06200 FQHC						62
. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0 0	0	63
. 00	OTHER REIMBURSABLE COST CENTERS	0	0	0) 0	0	70
	07100 AMBULANCE	0				0	71
. 00	07200 CORF	0	0	0	0	0	
	07300 CMHC	0	0	0	0 0	0	
. 00	07400 OTHER REI MBURSABLE COST	0	0	(0 0	0	74
. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		[1			80
. 00	08000 MALPRACTICE PREMIUMS & PAID LUSSES						81
. 00	08200 UTI LI ZATI ON REVI EW						82
. 00	08300 HOSPI CE	0	0	0	0 0	0	83
. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0 0	0	84
. 00	SUBTOTALS (sum of lines 1-84)	37, 135	37, 135	5, 225, 839	-2, 149, 718	11, 531, 101	89
. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0 0	0	90
. 00	09100 BARBER AND BEAUTY SHOP	0	0			6, 997	91
. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92
. 00	09300 NONPAID WORKERS	0	0	0	0 0	0	93
. 00	09400 PATIENTS LAUNDRY	0	0		0	0	94
. 00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 וי	0	95
. 00 . 00	Cross Foot Adjustments Negative Cost Centers						98
. 00 2. 00	Ũ	2, 092, 921	69, 594	776, 068	3	2, 149, 718	
50	Part I)	2, 3, 2, 721		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2
3.00	Unit cost multiplier (Wkst. B, Part I)	56. 359795	1. 874081			0. 186315	
4.00				52, 119		162, 862	104
	Part II) Unit cost multiplier (Wkst. B, Part			0.009973		0. 014115	105
5.00					1		1117

	Financial Systems LLOCATION - STATISTICAL BASIS	MAPLE GLE		No.: 315328 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/17/2023 2:3	pared:
	Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)		DI ETARY (MEALS SERVED)	NURSI NG	
	F	5.00	6.00	7.00	8.00	9.00	
		1					1 1 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 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	31, 325 900 410 4, 133 679 0 0 806 140 0 0	41, 362 0 0 0 0 0 0 0 0 0 0 0 0 0	30, 015 4, 133 679 0 0 806 140 0 0	125, 796 0 0 0 0 0 0 0 0	41, 362 0 0 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
30.00	03000 SKI LLED NURSI NG FACI LI TY	22, 788	41, 362	22, 788	125, 796	41, 362	30.00
	03100 NURSING FACILITY	0	0	0	0	0	31.00
	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0		0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	33.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
	04100 LABORATORY	0	0	0	0	0	41.00
	04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0780	0	0780	0	0	43.00
	04500 OCCUPATI ONAL THERAPY	359	0	359	0	0	45.00
	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	225 105	0	225 105	0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0		0	0	0	49.00
	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
(0.00	OUTPATIENT SERVICE COST CENTERS		0			0	1 (0.00
	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	
	06200 FQHC	0	0	0	0	0	62.00
	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	1					
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0	0	0	•
	07200 CORF	0	0		0	0	
	07300 CMHC	0	0	0	0	0	1
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW						82.00
	08300 HOSPI CE	0	0	0	0	0	•
84.00 89.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0 41 242	0 015	125 704	0 41 242	
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	31, 325	41, 362	30, 015	125, 796	41, 362	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	•
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0	0	0	
	09300 PATIENTS LAUNDRY	0	0	0	0	0	1
	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	
98.00	Cross Foot Adjustments						98.00
99.00 102.00	Negative Cost Centers	700 /01	2/2 /	0/4 000	4 707 570		99.00
102.00 103.00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	789, 681 25. 209290	368, 447 8. 907862			759, 731 18. 367850	
		138, 571	60, 506		281, 788		103.00
104.00	Part II)						

	Financial Systems LLOCATION - STATISTICAL BASIS	MAPLE GLEN		No.: 315328 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/17/2023 2:3	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 10.00	PHARMACY (COSTED REQUI S.) 11.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 12.00	SOCI AL SERVI CE (TOTAL PATI ENT DAYS) 13.00	NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED TI ME) 14. 00	
-	GENERAL SERVICE COST CENTERS						
	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	30, 624 0 0 0 0 0	0 0 0 0 0	20, 667, 522 0 0	41, 362 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	01500 ACTIVITIES	0	0	0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	30, 624 0 0 0	0 0 0	0	41, 362 0 0 0	0 0 0 0	31.00 32.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	20, 339	0	0	40.00
40.00	04100 LABORATORY	0	0	103, 764		0	40.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	21, 459	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	64	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	790, 555	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	1,009,371	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	428, 248	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00 48.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	180, 812	0	0	48.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	100, 012	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	1, 516		0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	
02.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>					02.00
60.00	06000 CLINIC	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	0		0	
71.00	07100 AMBULANCE	0	0	0	0	0	71.00
	07200 CORF	0	0	0	0	0	
	07300 CMHC 07400 OTHER REI MBURSABLE COST	0	0	0	0	0	
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	1 <u>0</u>	<u> </u>	0	/4.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW						82.00
83.00	08300 HOSPI CE	0	0	0	0	0	1
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	30, 624	0	20, 667, 522	41, 362	0	89.00
00.00			0	0	0	0	90.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	1
93.00	09300 NONPAI D WORKERS	Ő	0	0	o	0	1
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	1
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers		_			_	99.00
102.00		107, 085	0	142, 279	247, 701	0	102.00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	3. 496767	0. 000000	0. 006884	5. 988613	0.000000	103 00
103.00		1, 825	0.00000 0	53, 054			103.00
	Part II)	1,025	0	00,004	13, 400	0	
105.00		0. 059594	0. 000000	0.002567	0. 326048	0.000000	105.00
	11)						

STA	LLOCATION - STATISTICAL BASIS		Provi der No.: 315328	Period: From 01/01/2022	Worksheet B-1
				To 12/31/2022	Date/Time Prepare 5/17/2023 2:38 pm
		OTHER GENERAL		· · · · · · · · · · · · · · · · · · ·	
		SERVI CE			
	Cost Center Description	ACTI VI TI ES			
		(TOTAL PATIENT			
		DAYS)			
	GENERAL SERVICE COST CENTERS	15.00			
00	00100 CAP REL COSTS - BLDGS & FIXTURES				1
00	00200 CAP REL COSTS - MOVABLE EQUI PMENT				2
00	00300 EMPLOYEE BENEFITS				3
00	00400 ADMINI STRATI VE & GENERAL				4
00	00500 PLANT OPERATION, MAINT. & REPAIRS				5
00	00600 LAUNDRY & LINEN SERVICE				6
00	00700 HOUSEKEEPI NG				7.
00	00800 DI ETARY				8
00	00900 NURSING ADMINISTRATION				9.
0.00	01000 CENTRAL SERVICES & SUPPLY				10
. 00					11.
. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE				12
	01300 SUCTAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION				13
	01500 ACTIVITIES	41, 362			15
	INPATIENT ROUTINE SERVICE COST CENTERS	11,002			15
. 00	03000 SKI LLED NURSI NG FACI LI TY	41, 362			30
	03100 NURSING FACILITY	0			31
. 00	03200 CF/I D	0			32
. 00	03300 OTHER LONG TERM CARE	0			33
	ANCILLARY SERVICE COST CENTERS				
	04000 RADI OLOGY	0			40
	04100 LABORATORY	0			41
	04200 I NTRAVENOUS THERAPY	0			42
. 00	04300 OXYGEN (INHALATION) THERAPY	0			43
. 00	04400 PHYSI CAL THERAPY	0			44
. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0			45.
. 00	04700 ELECTROCARDI OLOGY	0			40
. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48
	04900 DRUGS CHARGED TO PATIENTS	0			49
. 00	05000 DENTAL CARE - TITLE XIX ONLY	0			50
. 00	05100 SUPPORT SURFACES	0			51
. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0			52
	OUTPATIENT SERVICE COST CENTERS				
. 00	06000 CLI NI C	0			60
. 00	06100 RURAL HEALTH CLINIC	0			61
. 00	06200 FQHC				62
. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0			63
00	OTHER REIMBURSABLE COST CENTERS	0			70
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0			70.
	07200 CORF	0			72
	07300 CMHC	0			73
	07400 OTHER REI MBURSABLE COST	0			74
	SPECIAL PURPOSE COST CENTERS				
. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES				80
. 00	08100 INTEREST EXPENSE				81
	08200 UTI LI ZATI ON REVI EW				82
. 00	08300 HOSPI CE	0			83
. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0			84
. 00	SUBTOTALS (sum of lines 1-84)	41, 362			89.
	NONREI MBURSABLE COST CENTERS				
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90
. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0			91.
. 00	09200 PHYSICIANS PRIVATE OFFICES	0			92.
	09400 PATIENTS LAUNDRY				94
. 00	09500 OTHER NONREI MBURSABLE COST CENTERS	Ő			95
. 00	Cross Foot Adjustments	Ŭ			98
0.00	Negative Cost Centers				99.
2. OC		198, 784			102
	Part I)				
3. 00		4.805957			103
4. OC		3, 773			104
	Part II)				
	Unit cost multiplier (Wkst. B, Part	0. 091219			105

Health Financial Systems	MAPLE GLEN CEN	TER		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIEN	T COST CENTERS	Provi der		Peri od:	Worksheet C	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
					5/17/2023 2:3	8 pm
Cost Center Description			Total (from			
			Wkst. B, Pt I	1	di vi ded by	
			col. 18)		col. 2	
			1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS			10.04	(0 (5(170	1
40. 00 04000 RADI 0L0GY			13, 34			
41.00 04100 LABORATORY			48, 36			•
42.00 04200 I NTRAVENOUS THERAPY			25, 53			
43.00 04300 OXYGEN (INHALATION) THERAPY			24, 01			
44.00 04400 PHYSI CAL THERAPY			401, 45			
45.00 04500 OCCUPATI ONAL THERAPY			457, 49			•
46.00 04600 SPEECH PATHOLOGY			178, 92	4 428, 248		•
47.00 04700 ELECTROCARDI OLOGY				0 0	0. 000000	•
48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS			23, 92		0. 000000	•
49.00 04900 DRUGS CHARGED TO PATIENTS			174, 64	1 180, 812		•
50.00 05000 DENTAL CARE - TITLE XIX ONLY				0 0	0. 000000	
51.00 05100 SUPPORT SURFACES			4, 85	6 1, 516		•
52.00 05200 OTHER ANCI LLARY SERVICE COST CENTERS				0 0	0.00000	52.00
OUTPATIENT SERVICE COST CENTERS			1			-
60. 00 06000 CLINIC				0 0	0. 000000	•
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER				0 0	0. 000000	
71. 00 07100 AMBULANCE				0 0	0. 000000	
100.00 Total			1, 352, 55	2, 556, 128		100. 00

Health Financial Systems	MAPLE GLE				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315328	Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pr	rogram Charge		Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	IENT COST					_
ANCI LLARY SERVI CE COST CENTERS			1			
40. 00 04000 RADI OLOGY	0. 656178			0 6, 115		
41. 00 04100 LABORATORY	0. 466135			0 5, 238		1
42. 00 04200 I NTRAVENOUS THERAPY	1. 190083			0 2, 574		1
43. 00 04300 OXYGEN (INHALATION) THERAPY	375. 265625			0 0	0	1 101 00
44. 00 04400 PHYSI CAL THERAPY	0. 507812			0 149,044		1
45. 00 04500 OCCUPATIONAL THERAPY	0. 453243			0 151, 825		1 101 00
46. 00 04600 SPEECH PATHOLOGY	0. 417805			0 64,067	0	1 .0.00
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	
	0.000000			0 (1.047	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS 50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 965871	63, 411		0 61, 247	0	50.00
51. 00 05100 SUPPORT SURFACES	0. 000000 3. 203166	0		0 120	0	
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 128		
0UTPATIENT SERVICE COST CENTERS	0.00000	0		0 0	0	52.00
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.000000	0		0	0	61.00
62. 00 06200 FQHC						62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of Lines 40 - 71)	0.00000	867, 990		0 440, 238	°	100.00
(1) For title V and XIX use columns 1, 2, and 4 on	I	007, 990	I	440, 230	0	1.00.00

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

Health Financial Systems	MAPLE GLE	N CENTER		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2022 To 12/31/2022		pared: 8 pm
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description						
					1.00	
PART II - APPORTIONMENT OF VACCINE COST		<u>/=</u>			0.0/5074	
1.00 Drugs charged to patients - ratio of			t C, column 3	, line 49)	0. 965871	1.00
2.00 Program vacci ne charges (From your r					6, 166	2.00
3.00 Program costs (Line 1 x line 2) (Tit	Te XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	5, 956	3.00
E, Part I, line 18) Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Dort A Nurcing	
cost center bescription	(From Wkst. B.			Cost (From	& Allied	
		(From Wkst. B,				
	18		Costs to Tota		for Pass	
	10	14)	Costs - Part		Through (Col.	
			(Col. 2 / Col		3 x Col. 4)	
			1)			
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COS	STS FOR NURSING &	ALLIED HEALTH				
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	13, 346	0	0.0000	0 6, 115	0	40.00
41. 00 04100 LABORATORY	48, 368		0.0000			41.00
42.00 04200 INTRAVENOUS THERAPY	25, 538		0.0000		0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	24,017	0	0.0000		0	43.00
44.00 04400 PHYSI CAL THERAPY	401, 453		0.0000			44.00
45.00 04500 OCCUPATI ONAL THERAPY	457, 490		0.0000		0	45.00
46.00 04600 SPEECH PATHOLOGY	178, 924	0	0.0000		0	46.00
47.00 04700 ELECTROCARDI OLOGY	0	C	0.0000		0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0.0000		0	48.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	174, 641		0.0000			49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0		0.0000		0	50.00
51.00 05100 SUPPORT SURFACES	4,856		0.00000		0	51.00
52.00 05200 OTHER ANCI LLARY SERVICE COST CENTERS			0.00000		0	52.00
100.00 Total (Sum of Lines 40 - 52)	1, 352, 558	0	1	440, 238	0	100.00

	1 i ty 1.00	PPS
INPATIENT DAYS 1.00 Inpatient days including private room days 2.00 Private room days 1.00 Medically necessary private room days applicable to the Program 1.00 Medically necessary private room days applicable to the Program 5.00 Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 8.00 8.00 9.00 Average private room charges from your records 9.00 9.01 9.01 9.02	41	1, 362
INPATIENT DAYS .00 Inpatient days including private room days .00 Private room days .01 Inpatient days including private room days applicable to the Program .02 Inpatient days including private room days applicable to the Program .01 Medically necessary private room days applicable to the Program .02 Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Conceral inpatient routine service cost/charge ratio (Line 5 divided by line 6) .00 General inpatient routine service cost/charge ratio (Line 5 divided by private room day 2) .01 Enter private room charges from your records .02 Average private room charges from your records .03 Average semi -private room charges from your records .04 Average per diem private room charge differential (Line 9 minus line 10, divided by semi -private room days) .00 Average per diem private room cost differential (Line 7 times line 12) .04 Private room cost differential adjustment (Line 2 times line 13) .05 General inpatient routine service cost per diem (Line 15 divided by line 1) .04 Adjusted general inpatient service cost per diem (Line 16 divided by line 1) .05 Program routine service cost per diem (Line	3	
 Inpatient days including private room days Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room charges from your records Average semi -private room charges from your records Average semi -private room charges from your records Average semi -private room charges from your records Average per diem private room charges from your records Average per diem private room charge (Semi -private room charges line 10, divided by semi -private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 	3	
 Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days) Outer semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room charges from your records Average per diem private room charges from your records Average per diem private room charge from your records Average per diem private room charge from your records Average per diem private room charge from your records Average per diem private room charge from your records Average per diem private room charge of the private room charges line 10, divided by semi-private room days) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Outer program general inpatient routine service cost (Line 17 plus line 18) 	3	
 Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room charges from your records Average semi-private room charges from your records Average semi-private room charges from your records Average per diem private room charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost per diem (Line 15 divided by line 1) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 		233
 Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room charges from your records Average semi-private room charges from your records Average semi-private room charges from your records Average semi-private room charges from your records Average per diem private room charge differential (Line 9 minus line 10, divided by semi-private room days) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost per diem (Line 15 divided by line 1) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 		
O0 Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 00 General inpatient routine service charges 00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 00 Enter private room charges from your records 00 Average private room charges from your records 0.00 Enter semi-private room charges from your records 0.00 Enter semi-private room charges from your records 0.00 Enter semi-private room charges from your records 0.00 Average semi-private room charge (Gemi-private room charges line 10, divided by semi-private room days) 0.00 Average per diem private room cost differential (Line 9 minus line 11) 0.00 Average per diem private room cost differential (Line 7 times line 12) 0.00 Private room cost differential adjustment (Line 2 times line 13) 0.00 General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS 0.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 0.00 Program routine service cost (Line 3 times line 16) 0.00 Medically necessary private room cost applicable to program (line 4 times line 13) 0.00 Total pr	12, 326	3, 027
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 00 General inpatient routine service charges 00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 00 Enter private room charges from your records 00 Average private room charges from your records 00 Enter semi-private room charges from your records 00 Enter semi-private room charges from your records 0.00 Enter semi-private room charges from your records 0.00 Average semi-private room charges from your records 0.00 Average per diem private room charge differential (Line 9 minus line 10, divided by semi-private room days) 0.00 Average per diem private room cost differential (Line 7 times line 12) 0.00 Average per diem private room cost differential (Line 7 times line 13) 0.00 General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS 0.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 0.01 Program routine service cost (Line 3 times line 16) 0.02 Medically necessary private room cost applicable to program (line 4 times line 13) 0.02 Total program general inpatient routine service cost (Line 17 plus line 18) <	12, 326	0
 General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room da 2) Enter semi-private room charges from your records Average semi-private room charges from your records Average semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 		6, 957
 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room da 2) Enter semi-private room charges from your records Average semi-private room charges from your records Average semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 		
 Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room da 2) Enter semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 	18, 990	
 Average private room per diem charge (Private room charges line 8 divided by private room da 2) Enter semi-private room charges from your records Average semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 		49118
 2) 2) 2) 2) 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 200 Average per diem private room charge differential (Line 9 minus line 11) 200 Average per diem private room cost differential (Line 7 times line 12) 200 Private room cost differential adjustment (Line 2 times line 13) 200 General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS 200 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 200 Program routine service cost (Line 3 times line 16) 200 Medically necessary private room cost applicable to program (line 4 times line 13) 200 Total program general inpatient routine service cost (Line 17 plus line 18) 		2, 259
 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 	s, line 52	24.72
 semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 	18, 868	8, 051 1
 Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 	45	58.75 1
 Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) 	6	65.97 1
.00General inpatient routine service cost net of private room cost differential (Line 5 minus PROGRAM INPATIENT ROUTINE SERVICE COSTS.00Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) .00.00Medically necessary private room cost applicable to program (line 4 times line 13) 	4	42.82 1
PROGRAM INPATIENT ROUTINE SERVICE COSTS .00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) .00 Program routine service cost (Line 3 times line 16) .00 Medically necessary private room cost applicable to program (line 4 times line 13) .00 Total program general inpatient routine service cost (Line 17 plus line 18)	ç	9, 977 1
 .00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) .00 Program routine service cost (Line 3 times line 16) .00 Medically necessary private room cost applicable to program (line 4 times line 13) .00 Total program general inpatient routine service cost (Line 17 plus line 18) 	ne 14) 12, 316	<u>6, 980</u> 1
.00 Medically necessary private room cost applicable to program (line 4 times line 13) .00 Total program general inpatient routine service cost (Line 17 plus line 18)	29	97.78 1
00 Total program general inpatient routine service cost (Line 17 plus line 18)	901	1, 380 1
		0 1
.00 Capital related cost allocated to inpatient routine service costs (From Wkst, B. Part II co	901	1,380 1
line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	umn 18, 2,047	7, 117 2
.00 Per diem capital related costs (Line 20 divided by line 1)	4	49.49 2
.00 Program capital related cost (Line 3 times line 21)	149	9,806 2
.00 Inpatient routine service cost (Line 19 minus line 22)	751	1, 574 2
00 Aggregate charges to beneficiaries for excess costs (From provider records)		0 2
00 Total program routine service costs for comparison to the cost limitation (Line 23 minus lin	24) 751	1,574 2
.00 Enter the per diem limitation (1)		2
.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		2
.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27 (Transfer to Worksheet E, Part II, line 4) (See instructions)		2

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	41, 362	1.00
2.00	Program inpatient days (see instructions)	3, 027	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. 073183	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00
2.00 3.00 4.00	Program inpatient days (see instructions) Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX) Nursing & allied health ratio. (line 2 divided by line 1)	3, 027 0 0. 073183	2.00 3.00 4.00

Heal th	Financial Systems MAPLE GLEN	CENTER	In Lie	u of Form CMS-2	2540-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provi der No.: 315328	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Pre	pared:		
				5/17/2023 2:3			
	Title XVIII Skilled Nursing						
			Facility				
				1.00			
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBL	IRSEMENT		1.00			
1.00	Inpatient PPS amount (See Instructions)			2, 250, 499	1.00		
2.00	Nursing and Allied Health Education Activities (pass through	payments)		2,200,177	2.00		
3.00	Subtotal (Sum of Lines 1 and 2)	F=J		2, 250, 499	3.00		
4.00	Primary payor amounts			0	4.00		
5.00	Coinsurance			314, 118	5.00		
6.00	Allowable bad debts (From your records)			139, 839	6.00		
7.00	Allowable Bad debts for dual eligible beneficiaries (See ins	tructions)		118, 475	7.00		
8.00	Adjusted reimbursable bad debts. (See instructions)	,		90, 895	8.00		
9.00	Recovery of bad debts - for statistical records only			0	9.00		
10.00	Utilization review			0	10.00		
11.00	Subtotal (See instructions)			2,027,276	11.00		
12.00	Interim payments (See instructions)			2,012,713	12.00		
13.00	Tentati ve adjustment			0	13.00		
14.00							
14.50							
14.55	Demonstration payment adjustment amount after sequestration			5, 538	14.55		
14.75	Sequestration for non-claims based amounts (see instructions))		1, 145	14.75		
14.99	Sequestration amount (see instructions)			31, 893	14.99		
15.00	Balance due provider/program (see Instructions)			-24, 013			
16.00	Protested amounts (Nonallowable cost report items in accordan			0	16.00		
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSE	ER OF COST OR CHARGES - T	ITLE XVIII ONLY				
17.00	Ancillary services Part B			0	17.00		
18.00	Vaccine cost (From Wkst D, Part II, line 3)			5, 956	18.00		
19.00	Total reasonable costs (Sum of lines 17 and 18)			5, 956	19.00		
20.00	Medicare Part B ancillary charges (See instructions)			6, 166	20.00		
21.00	Cost of covered services (Lesser of line 19 or line 20)			5, 956			
22.00	Primary payor amounts			0	22.00		
	Coinsurance and deductibles			0	23.00		
24.00	Allowable bad debts (From your records)	tructions)		0	24.00		
	Allowable Bad debts for dual eligible beneficiaries (see ins Adjusted reimbursable bad debts (see instructions)	tructions)		0	24.01 24.02		
	Subtotal (Sum of Lines 21 and 24, minus Lines 22 and 23)			5, 956			
26.00	Interim payments (See instructions)			2, 329			
28.00				2, 329	27.00		
27.00	Other Adjustments (See instructions) Specify			0	27.00		
28.00	Demonstration payment adjustment amount before sequestration			0	28.00		
28.55	Demonstration payment adjustment amount before sequestration			0	28.55		
	Sequestration amount (see instructions)			75	28.99		
	Bal ance due provi der/program (see instructions)			3, 552			
	Protested amounts (Nonallowable cost report items) in accorda	ance with CMS Pub 15-2 s	ection 115 2		30.00		

lealth Financial Systems	MAPLE GLEN CE			u of Form CMS-	2540-	
CALCULATION OF REIMBURSEMENT SE	TTLEMENT TITLE V and TITLE XIX ONLY	Provider No.: 315328	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part II Date/Time Pre 5/17/2023 2:3		
		Title XIX	Skilled Nursing Facility	PPS		
				1 00		
COMPLITATION OF NET COST (1.00	-	
1.00 COMPUTATION OF NET COST C				0	1.	
	Cost (From Worksheet D-1, Pt. II, lin	ю Б)		0		
3.00 Outpatient services	JUST (TTUIL WURKSHEET D-1, FT. 11, TT			0		
4.00 Inpatient routine service	as (see instructions)			0		
	cians' compensation (from provider re	cords)		0		
5.00 Cost of covered services				0		
	between semiprivate accommodations and	lless than semi-private	accommodations	0		
3.00 SUBTOTAL (Line 6 minus li		ress than som private		0		
9.00 Primary payor amounts				0		
10.00 Total Reasonable Cost (Li	ne 8 minus line 9)			0		
REASONABLE CHARGES					1	
1.00 Inpatient ancillary servi	ce charges			0	11.	
2.00 Outpatient service charge				0	12.	
3.00 Inpatient routine service				0	13.	
4.00 Differential in charges k	00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations					
5.00 Total reasonable charges		·		0	15.	
CUSTOMARY CHARGES						
6.00 Aggregate amount actually	collected from patients liable for p	ayment for services on	a charge basis	0	16.	
7.00 Amounts that would have b	been realized from patients liable for	payment for services o	n a charge basis	0	17.	
	le in accordance with 42 CFR 413.13(e)					
	17 (not to exceed 1.000000)			0.00000		
9.00 Total customary charges (0	19.	
COMPUTATION OF REIMBURSEN						
0.00 Cost of covered services	(see Instructions)			0		
1.00 Deductibles				0		
2.00 Subtotal (Line 20 minus I	ine 21)			0		
3.00 Coi nsurance				0		
24.00 Subtotal (Line 22 minus I				0	1	
25.00 Allowable bad debts (from	5			0		
26.00 Subtotal (sum of lines 24				0		
	neficiaries for excess costs erroneous	ly collected based on c	orrection of	0	27.	
cost limit	istion resulting from provider termin	ation on a deereese in		0	20	
18.00 Recovery of excess depred utilization	ciation resulting from provider termin	action of a decrease in	program	0	28.	
29.00 Other Adjustments (see in	structions) Specify			0	29.	
, , , , , , , , , , , , , , , , , , ,	or cost reporting periods resulting f	rom disposition of donr	ociable accete (0		
if minus, enter amount ir				0	30.	
	pr minus lines 29, and 30, minus lines	27 and 28)		0	31.	
32.00 Interim payments		2, 414 20)		0		
	gram (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0		
		storpayments in parent		0	1 00.	

IALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315328	Period: From 01/01/2022 To 12/31/2022		
		Ti tl	e XVIII	Skilled Nursing		0 pm
		Inpatien	t Part A	Facility Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		2, 104, 6	75 0	2, 329 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3
)4				0	0	3
)5	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM	06/28/2022	91, 9	62	0	3
51		00/20/2022		0	Ő	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-91, 9	62	0	3
~~	- 3.98)		2 010 7	10	2, 220	
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		2, 012, 7	13	2, 329	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
)1	Program to Provider TENTATIVE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtatal (Sum of Linos E 01 E 40 minus sum of Linos E E0			0	0	5
7	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0	>
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER			0	3, 552	6
)2	PROVIDER TO PROGRAM		24, 0		0	6
00	Total Medicare program liability (see instructions)		1, 988, 7		5, 881	7
			Contra	actor Name	Contractor Number	
					Number	

 8.00
 Name of Contractor

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

	SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet G Date/Time Pre 5/17/2023 2:3	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	legato	1.00	2.00	3.00	4.00	
-	Assets					1
	Cash on hand and in banks	3, 742		0 0	0	, i
	Temporary investments	0		0 0	0	
	Notes receivable	0		o o	0	
00 /	Accounts receivable	2, 125, 906		0 0	0	
00 0	Other receivables	-23, 111		0 0	0	
00	Less: allowances for uncollectible notes and accounts	-348, 734		0 0	0	
	recei vabl e					
	Inventory	48, 340		0 0	0	
	Prepaid expenses	-34, 463		0 0	0	
	Other current assets	695		0 0	0	
	Due from other funds	0		0 0	0	
	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 772, 375		0 0	0	1
	FIXED ASSETS			0 0	0	1 1
	Land Land improvements	282, 993		0 0	0	
	Less: Accumulated depreciation	-230, 135		0 0	0	
	Buildings	4, 952, 411			0	
	Less Accumulated depreciation	-893, 668		0 0	0	
	Leasehold improvements	1, 514, 297		0 0	0	
	Less: Accumulated Amortization	-676, 471		0 0	0	
	Fixed equipment	324, 095		0 0	0	
	Less: Accumulated depreciation	-204, 472		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Less: Accumulated depreciation	0		0 0	0	
	Major movable equipment	912, 280		o o	0	2:
	Less: Accumulated depreciation	-720, 653		o o	0	2
00 1	Minor equipment - Depreciable	0		0 0	0	2
	Minor equipment nondepreciable	0		0 0	0	20
	Other fixed assets	0		0 0	0	2
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	5, 260, 677		0 0	0	2
C	OTHER ASSETS					
	Investments	0		0 0	0	
	Deposits on leases	0		0 0	0	
	Due from owners/officers	-16, 261, 857		0 0	0	
	Other assets	0		0 0	0	
	TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	-16, 261, 857		0 0	0	
	TOTAL ASSETS (Sum of lines 11, 28, and 33)	-9, 228, 805		0 0	0	34
	Liabilities and Fund Balances					-
	Accounts payable	773, 077		0 0	0	3
	Salaries, wages, and fees payable	1,13,077		0 0	0	
	Payroll taxes payable				0	
	Notes & Loans payable (Short term)			0 0	0	
	Deferred income	0		0 0	0	
	Accelerated payments	0			-	4
	Due to other funds	7, 937		0 0	0	
	Other current liabilities	1, 756, 532		0 0	0	
	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 537, 546		0 0	0	
	ONG TERM LIABILITIES					
	Mortgage payable	10, 896, 112		0 0	0	44
	Notes payable	0		0 0	0	4
	Unsecured Loans	0		0 0	0	4
00 1	Loans from owners:	0		0 0	0	
00 0	Other long term liabilities	0		0 0	0	4
	API C DI STRI BUTI ONS; R/E EARNI NGS	-21, 059, 008		0 0	0	
	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-10, 162, 896		0 0	0	
	TOTAL LIABILITIES (Sum of lines 43 and 50)	-7, 625, 350		0 0	0	5
	CAPITAL ACCOUNTS		1			
	General fund balance	-1, 603, 455				5
	Specific purpose fund			0		5
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		5!
	Governing body created - endowment fund balance			0	-	50
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	1 (00 /55			~	
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-1, 603, 455 -9, 228, 805		0	0	
00						

Heal th	Financial Systems	MAPLE GLEN	CENTER		In Lie	eu of Form CMS-:	2540-10
	ENT OF CHANGES IN FUND BALANCES			No.: 315328	Period: From 01/01/2022 To 12/31/2022	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1 00	Fund halances at beginning of pariod	1.00	2.00	3.00	4.00	5.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	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) Total deductions (sum of lines 13 - 17)	0 0 0 0 0 0 0 0 0 0 0 0 0	0 -1, 603, 455 -1, 603, 455 0 -1, 603, 455				$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-1, 603, 455		C		19.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	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 0 0 0 0 0		0 0 0 0		$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00 \end{array}$
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		0 0		15. 00 16. 00 17. 00 18. 00 19. 00

Heal th	Financial Systems MAPLE GL	EN CENTER			In Lie	u of Form CMS-2	2540-10		
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315328	То	n 01/01/2022 12/31/2022	Worksheet G-2 Parts I-II Date/Time Pre 5/17/2023 2:3			
	Cost Center Description		Inpati ent	(Outpati ent	Total			
			1.00		2.00	3.00			
	PART I – PATIENT REVENUES								
	General Inpatient Routine Care Services								
1.00	KILLED NURSING FACILITY		18, 111, 394			18, 111, 394	1.00		
2.00	URSING FACILITY		0		0	2.00			
3.00	ICF/IID		0		0	3.00			
4.00	OTHER LONG TERM CARE		0		0	4.00			
5.00	Total general inpatient care services (Sum of lines 1 - 4))	18, 111, 3	94		18, 111, 394	5.00		
	All Other Care Services								
6.00	ANCI LLARY SERVI CES		2, 563, 6	85	0	2, 563, 685	6.00		
7.00	CLINIC		1		0	0	7.00		
8.00	HOME HEALTH AGENCY COST				0	0	8.00		
9.00	AMBULANCE				0	0	9.00		
10.00	RURAL HEALTH CLINIC				0	0	10.00		
10. 10	FQHC				0	0	10. 10		
11.00	СМНС				0	0	11.00		
11.10	CORF				0	0	11, 10		
12.00	HOSPI CE			0	0	0	12.00		
	OTHER (SPECIFY)			0	0	0	13.00		
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer co	umn 3 to	20, 675, 0	79	0	20, 675, 079	14.00		
	Worksheet G-3, Line 1)				-				
	Cost Center Description								
					1.00	2.00			
	PART II - OPERATING EXPENSES								
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					14, 529, 284	1.00		
2.00	Add (Specify)				0		2.00		
3.00					0		3.00		
4.00					0		4.00		
5.00					0		5.00		
6.00					0		6.00		
7.00					0		7.00		
8.00	Total Additions (Sum of lines 2 - 7)					0	8.00		
9.00	Deduct (Specify)				0		9.00		
10.00					0		10.00		
11.00					0		11.00		
12.00					0		12.00		
13.00					0 0		13.00		
14.00	Total Deductions (Sum of lines 9 - 13)				Ű	0	14.00		
	Total Operating Expenses (Sum of Lines 1 and 8, minus Line	e 14)				14, 529, 284			
10.00				1	I	11, 027, 204	.0.00		

Heal th	Financial Systems	MAPLE GLEN CENTER		In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES			No.: 315328	Peri od: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prep 5/17/2023 2:38	bared:
				-	1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	col. 3. line 14)			20, 675, 079	1.00
2.00	Less: contractual allowances and discounts on pa				7, 771, 222	2.00
3.00	Net patient revenues (Line 1 minus line 2)				12, 903, 857	3.00
4.00	Less: total operating expenses (From Worksheet G	-2, Part II, line 15)			14, 529, 284	4.00
5.00	Net income from service to patients (Line 3 minu				-1, 625, 427	5.00
	Other income:		· · ·			
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from communications (Telephone and Int	ernet service)			0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and guests				0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical suppli	es to other than patients			0	16.00
17.00	Revenue from sale of drugs to other than patient	S			0	17.00
18.00	Revenue from sale of medical records and abstrac	ts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flower, coffee shops, cantee	n			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of skilled nursing space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	MI SC I NCOME				21, 972	24.00
24.50	COVI D-19 PHE Funding				0	24.50
25.00	Total other income (Sum of lines 6 - 24)				21, 972	25.00
26.00	Total (Line 5 plus line 25)				-1, 603, 455	26.00
27.00	Other expenses (specify)				0	27.00
28.00					0	28.00
29.00					0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)				0	30.00
31.00	Net income (or loss) for the period (Line 26 min	us line 30)			-1, 603, 455	31.00