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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315158
Period:
From 01/01/2021
To 12/31/2021
Worksheet S
Parts I, II & III
Date/Time Prepared:
5/19/2022 1: 24 pm

PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 5/19/2022 1:24 pm use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[0]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received: for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIDGEWOOD CENTER (315158) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Dia	ne Morris	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

		Title XVIII			
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1.00	2.00	3. 00	4. 00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	22, 307	524	0	1. 00
2.00 NURSING FACILITY	0			0	2. 00
3. 00 I CF/I I D				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	22, 307	524	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.

	D NURSING FACILITY AND SKILLED NURSING F X INDENTIFICATION DATA	FACILITY HEALTH	1 CARE	Provi der No.	: 315158	Period: From 01/01/	/2021	Workshee Part I	et S-2	2540-10
JIVII LL	A TINDENTITICATION DATA					To 12/31/		Date/Tim 5/19/202		
	1.00		2.00		3. 00					, i
00	Skilled Nursing Facility and Skilled Nu Street: 330 FRANKLIN TURNPIKE	PO Box:	Complex Ad	dress:						1.00
00	City: RIDGEWOOD	State: N.	J	Zi p Code: 074	450					2.00
. 00	County: BERGEN	CBSA Code		Urban/Rural:	: U					3.00
01		CBSA Code		ont Nama	Dravi dan	Data	Dayma	nt Custs	m /D	3. 0
			Compon	ent Name	Provi der CCN	Date Certified	Payme	ent Syste O, or N)		
							V	XVIII	XI X	
	CNE and CNE Band Community I doubt 6: anti-		1	. 00	2. 00	3. 00	4. 00	5.00	6. 00	
. 00	SNF and SNF-Based Component Identificat		RI DGEWOOD C	FNTFR	315158	06/04/1975	l N	P	P	4.00
. 00	Nursing Facility									5. 00
. 00	I CF/IID									6.00
. 00 . 00	SNF-Based HHA SNF-Based RHC									7. 00 8. 00
. 00	SNF-Based FQHC									9.00
0. 00	SNF-Based CMHC									10.00
	SNF-Based OLTC SNF-Based HOSPICE									11. 00 12. 00
	SNF-Based CORF									13.00
						From:		To:		
4 00	Cost Reporting Period (mm/dd/yyyy)					1.00		2.00		14. 00
	Type of Control (See Instructions)					01/01/2	4	12/31/2	2021	15.00
	, ,							Y/N		
	Type of Expectanding Chilled Numeing Fo	0111+11						1. 00)	
5. 00	Type of Freestanding Skilled Nursing Falls this a distinct part skilled nursing		meets the i	reguirements	set forth	in 42 CFR		N		16. 00
	section 483.5?	,		·				N		
7. 00										17.00
8. 00	Are there any costs included in Workshee	et A that resul	lted from t	ransactions v	with relat	ed		Υ		18.00
	organizations as defined in CMS Pub. 15	-1, chapter 10°								
0 00	Miscellaneous Cost Reporting Information If this is a low Medicare utilization co	n ost roport in	di cata wi th	a "V" for	vos or "N	" for no		N		 19. 00
	If line 19 is yes, does this cost report						e	N		19.00
	utilization cost report, indicate with a	a "Y", for yes,	, or "N" for	no.						
0 00	Depreciation - Enter the amount of depressing the Depressing the Depreciation - Enter the amount of depressing the Depression - Enter the Amount of Depression - Enter the Amount of Depression - Enter the Amount of Depression - Enter the Depression - Enter the Amount of Depression - Enter the Depressi	eciation repor	ted in this	SNF for the	method in	di cated on	Li nes		72 242	20.00
	Declining Balance								73, 203 C	21.00
2. 00	Sum of the Year's Digits								C	22. 00
	Sum of line 20 through 22 If depreciation is funded, enter the ba	alanaa aa af +1	ha and of th	no nominal					73, 263	23.00
	Were there any disposal of capital asse				(Y/N)			N	C	24. 00 25. 00
	Was accelerated depreciation claimed on					porting per	i od?	N		26.00
7 00	(Y/N)							NI.		27.00
7.00	Did you cease to participate in the Mediapplies? (Y/N)	icare program a	at end of ti	ne period to	which this	s cost repo	rt	N		27.00
8. 00	Was there a substantial decrease in heal	lth insurance p	proportion o	of allowable	cost from	prior cost		N		28. 00
	reports? (Y/N)						Dart	A Part B	Othor	
								2.00		
	If this facility contains a public or no									
	of the lower of the costs or charges en exemption.	ter "Y" for ea	cn componen	t and type o	servi ce	tnat qualif	res f	or the		
9. 00	Skilled Nursing Facility						N	N		29.00
0.00	Nursing Facility								N	30.00
2. 00	ICF/IID SNF-Based HHA						N	l N	N	31.00
3. 00	SNF-Based RHC						l IN	N N		33.00
. 00	SNF-Based FQHC							N		34.00
	SNF-Based CMHC							N		35.00
J. UU	SNF-Based OLTC					Y/N				36.00
						1.00		2. 00)	
7. 00	Is the skilled nursing facility located				er as a SN	F Y				37. 00
8. 00	regardless of the level of care given for Are you legally-required to carry malpra			s: (Y/N)		N				38.00
	Is the mal practice a "claims-made" or "o	occurrence" pol	licy? If the	e policy is		1				39.00
	"claims-made" enter 1. If the policy is	"occurrence",	enter 2.							
	erariis illade cirter 1: 11 the porrey 15									
	Total iii iii ii				Premiums 1 00	Paid Los	ses S	SelfInsu 3 00		
. 00	List malpractice premiums and paid loss	es:			Premi ums 1.00	Paid Los 2. 00 0	sses S	3.00 0		41. 00

Health Financial Systems RIDGEWOOD CENTER In Lieu					2540-10			
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315158	Peri od:	Worksheet S-2				
COMPLEX INDENTIFICATION DATA			From 01/01/2021	Part I				
To 12/31/202				Date/Time Pre				
				5/19/2022 1: 2	4 pm			
		Y/N						
				1. 00				
42.00 Are malpractice premiums and paid loss	2.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost							
center? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listing cost	centers and					
amounts.		· ·						
43.00 Are there any home office costs as def	ined in CMS Pub. 15-1, Ch	apter 10?		Υ	43.00			
44.00 If line 43 is yes, enter the home offi	ce chain number and enter	the name and address	of the home	HB0067	44. 00			
office on lines 45, 46 and 47.								
1.00	2.00		3. 00					
If this facility is part of a chain or	ganization, enter the nam	e and address of the h	nome office on the	lines				
bel ow.								
45. 00 Name: GENESIS HEALTHCARE	Contractor's Name: NOVITA	1	45. 00					
46.00 Street: 101 EAST STATE STREET	PO Box:				46. 00			
47.00 City: KENNETT SQUARE								

	Financial Systems	RI DGEWOOD CENTER				eu of Form CMS-	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Pr	rovi der		Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre	epared:
					Y/N	5/19/2022 1:2 Date	24 pm
	C		\/ \ \ \ \ \ - \ .	- \/ !!	1.00	2.00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column i,	"Y" TOI	r yes or "N"	ror No. For all	the date	
1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter-instructions)				N		1.00
				Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Program?	' If	1. 00 N	2. 00	3. 00	2.00
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and in	col umn				
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or relationships? (see instructions)	., chain home offices, d to the provider or i I, or members of the b	drug ts oard	Y			3. 00
	retationships: (see Thati detrons)			Y/N	Type	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" for te copy or enter date		Y	С		4. 00
5.00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If reconciliation.	revenues different fr		N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00		
6. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	ool? (Y/N) Column 2:	Is the p	provider the	N	N	6. 00
7. 00 8. 00	Were costs claimed for Allied Health Program. Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so	ng the cost reporting		for Nursing	N N		7. 00 8. 00
	(7.1.) e	00 1 110 21 40 21 0110			1	Y/N 1.00	
	Bad Debts						
9. 00 10. 00	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				t reporting	Y N	9. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance waive	d? If "`	Y", see instr	uctions.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting period	? f "Y			N	12. 00
		Description	-	Pa Y/N	rt A Date	Part B Y/N	
	T	0		1.00	2. 00	3. 00	
13. 00	PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			N		N	13. 00
14. 00	4. (see Instructions.) 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.			Υ	03/19/2022	Y	14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?			N		N	17. 00
	Describe the other adjustments:		I				

Heal th	Financial Systems RIDGEWO	OD CEN	TER		In Lieu of Form CMS-2540-10				540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			Provi der	No.: 315158		riod: om 01/01/2021 12/31/2021	Worksheet S- Part II Date/Time Pr 5/19/2022 1:	ера	ared:
	· · · · · · · · · · · · · · · · · · ·						37 177 2022 1.	Í	рііі
			1.	00		2.	00		
	Cost Report Preparer Contact Information								
19.00	Enter the first name, last name and the title/position	JEAN			PF	RICE			19.00
	held by the cost report preparer in columns 1, 2, and 3, respectively.								
20. 00	Enter the employer/company name of the cost report	GENE	SIS HEALTH	ICARE					20. 00
21. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	4108	044481		JE	EAN. PRI CE@GENE	ESI SHCC. COM		21. 00

Health Financial Systems RIDGEWOOD CENTER In Lieu of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

RIDGEWOOD CENTER

Provider No.: 315158
Period:
From 01/01/2021 Part II
Part (Time Proposed)

Pask Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "", enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R of total and the provider's records for all location? If either col. 1 or 3 is "" enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R of for total and the provider's records for all location? If either col. 1 or 3 is "" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "", 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 "V", see Instructions of other PS&R data for corrections of other PS&R data for other? 17.00 If line 13 or 14 is "y", then were adjustments made to PS&R data for other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "y" see Instructions. 19.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 19.00 Enter the employer/company name of the cost report preparer. 20.00 Enter the employer/company name of the cost report preparer in columns 1 and 2, respectively.	COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2021	
PS&R Data						
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.) 14.00 Was the cost report prepared using the PS&R of 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. 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. 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. 17.00 If line 13 or 14 is "y", then were adjustments made to PS&R data for Other? Describe the other adjustments. 18.00 Was the cost report prepared only using the provider's records? If "y" see Instructions. 19.00 East Report Preparer Contact Information 19.00 East Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report preparer. 21.00 Enter the employer/company name of the cost report preparer.						
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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.) 14.00 Was the cost report prepared using the PS&R of 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. 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. 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. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 20.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. 21.00 Enter the telephone number and email address of the cost						
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prepare this cost report in cols. 2 and 4. (see Instructions.) 14. 00 Was the cost report prepared using the PS&R for ottal and the provider's records for allocation? If either col. 1 or 3 is "V" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 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. 16. 00 If line 13 or 14 is "V", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17. 00 If line 13 or 14 is "V", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18. 00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19. 00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20. 00 Enter the employer/company name of the cost report preparer. 21. 00 Enter the telephone number and email address of the cost						
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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. 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. 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. 17.00 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. 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report preparer. 21.00 Enter the telephone number and email address of the cost						
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21.00 Enter the telephone number and email address of the cost 21.00			•			
report preparer in columns 1 and 2, respectively.	21.00		of the cost			21. 00
		report preparer in columns 1 and 2, respectiv	el y.			

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

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

Provider No.: 315158 | Period: Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared:

5/19/2022 1:24 pm Inpatient Days/Visits Title XVIII Component Number of Beds Bed Days Title V Title XIX Avai I abl e 1.00 4.00 5.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 90 32, 850 1, 692 20, 308 1. 00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 Ω 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 7.00 Ω 7.00 8.00 Total (Sum of lines 1-7) 1,692 20, 308 8.00 Inpatient Days/Visits Di scharges Component 0ther Total Title V Title XVIII Title XIX 6.00 8.00 9. 00 10.00 SKILLED NURSING FACILITY 1.00 2,001 24, 001 1.00 43 NURSING FACILITY 2.00 2 00 0 0 3.00 ICF/IID 0 3.00 4.00 HOME HEALTH AGENCY COST 0 4.00 Other Long Term Care SNF-Based CMHC 0 5.00 5.00 6.00 6 00 6.10 SNF-Based CORF 6.10 HOSPI CE 7.00 7.00 Total (Sum of lines 1-7) 2,001 8.00 24,001 43 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 11. 00 13.00 14.00 15.00 12.00 1.00 SKILLED NURSING FACILITY 0. 00 472. 28 1.00 49 113 80.57 2.00 NURSING FACILITY 0 0.00 0.00 2.00 ICF/IID 0 3.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 0.00 7 00 0 00 0 00 7 00 Total (Sum of lines 1-7) 8.00 49 113 0.00 80.57 472.28 8.00 Average Length Admi ssi ons of Stay Component Title V Title XVIII 0ther Title XIX Total 18.00 19.00 20.00 16.00 17.00 1.00 SKILLED NURSING FACILITY 212.40 42 27 56 1.00 2.00 NURSING FACILITY 0.00 0 0 2.00 ICF/IID 3.00 0.00 0 3.00 0 HOME HEALTH AGENCY COST 4 00 4 00 5.00 Other Long Term Care 0.00 5.00 6.00 SNF-Based CMHC 6.00 6.10 SNF-Based CORF 6.10 7.00 HOSPI CE 0.00 \cap 0 7.00 Total (Sum of lines 1-7) 8.00 212.40 42 27 56 8.00 Admi ssi ons Full Time Equivalent Component Total Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 125 53. 57 0.00 1. 00 NURSING FACILITY 0.00 2.00 2.00 0.00 0 3.00 LCF/LLD 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0.00 0.00 5.00 SNF-Based CMHC 0.00 0.00 6.00 6.00 6.10 SNF-Based CORF 0.00 0.00 6. 10 7.00 HOSPI CE 0.00 0.00 7.00 Total (Sum of lines 1-7) 125 53.57 0.00 8.00 8.00

				T	0 12/31/2021	Date/Time Prep 5/19/2022 1: 24	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1. 00	Total salaries (See Instructions)	3, 036, 536	0	3, 036, 536		1	1. 00
2.00	Physician salaries-Part A	0	0	0	0. 00		2.00
3.00	Physician salaries-Part B	0	0	0	0. 00		3.00
4.00	Home office personnel	0	0	0	0. 00		4.00
5.00	Sum of lines 2 through 4	0	0	0	0. 00		5.00
6.00	Revised wages (line 1 minus line 5)	3, 036, 536	0	3, 036, 536			6.00
7.00	Other Long Term Care	0	0	0	0. 00		7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0. 00		8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	0	0.00		10.00
11. 00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	3, 036, 536	0	3, 036, 536	111, 416. 00	27. 25	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
	Contract Labor: Patient Related & Mgmt	1, 661, 938	l .	1,001,700			14.00
15. 00	J	30, 114	l .	30, 114			15.00
16. 00		332, 349	0	332, 349	6, 205. 00	53. 56	16.00
	WAGE-RELATED COSTS						
17. 00	,	582, 723	0	582, 723			17.00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18.00
19. 00		0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21. 00		0	0	0			21.00
22. 00		582, 723	0	582, 723			22.00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION RI DGEWOOD CENTER

				Ţ	o 12/31/2021	Date/Time Prep 5/19/2022 1:24	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col . 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	386, 174	0	386, 174	13, 171. 00	29. 32	2. 00
3.00	Plant Operation, Maintenance & Repairs	61, 680	0	61, 680	2, 120. 00	29. 09	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	0	0.00	0.00	5. 00
6.00	Di etary	0	0	0	0.00	0.00	6. 00
7.00	Nursing Administration	297, 680	-47, 714	249, 966	4, 827. 00	51. 78	7. 00
8.00	Central Services and Supply	0	15, 490	15, 490	675.00	22. 95	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	32, 224	32, 224	1, 416. 00	22. 76	10. 00
11. 00	Soci al Servi ce	122, 855	0	122, 855	3, 747. 00	32. 79	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	120, 164	0	120, 164	6, 155. 00	19. 52	13. 00
14. 00	Total (sum lines 1 thru 13)	988, 553	[c	988, 553	32, 111. 00	30. 79	14. 00

Health Financial Systems	RI DGEWOOD CENTER	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315158	
		From 01/01/2021 Part IV

	To 12/31/2021	Date/Time Prep 5/19/2022 1:24	
		Amount	<u></u>
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS	11.00	
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	25, 240	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4. 00	Prior Year Pension Service Cost	0	4. 00
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	Ü	
5.00	401K/TSA Plan Administration fees	0	5.00
6. 00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
7.00	HEALTH AND INSURANCE COST	Ü	7.00
8. 00	Heal th Insurance (Purchased or Self Funded)	188, 374	8.00
9. 00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11.00
		0	12.00
13. 00	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0	13. 00
		0	14. 00
15. 00	Workers' Compensation Insurance	105, 198	
16. 00		103, 148	16.00
10.00	Non cumulative portion)	U	16.00
	TAXES		
17 00	FICA-Employers Portion Only	225, 721	17. 00
18. 00	Medicare Taxes - Employers Portion Only	223, 721	18.00
	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	38, 189	
20.00	OTHER	38, 189	20.00
21 00	·	0	21 00
	Executive Deferred Compensation	0	21. 00 22. 00
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 - 23)	582, 722	24. 00
		Amount	
		Reported 1.00	
	Part P. Other than Care Paleted Coct	1.00	
25 00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)	^	25. 00
25.00	OTHER WAGE KELATED COSTS (SPECIFY)	ا	∠5. UU

				T	12/31/2021	Date/Time Prep 5/19/2022 1: 2	pared:
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	
	, , ,	Reported		Salaries (col.		Wage (col. 3 ÷	
		·		1 + col . 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	282, 476	41, 632				1.00
2.00	Licensed Practical Nurses (LPNs)	900, 927	145, 647		·		2.00
3.00	Certified Nursing Assistant/Nursing	864, 580	245, 252	1, 109, 832	46, 154. 00	24. 05	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	2, 047, 983	432, 531	2, 480, 514	79, 305. 00		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		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. 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)	104, 564		104, 564	·		14. 00
15. 00	Licensed Practical Nurses (LPNs)	109, 497		109, 497	1, 628. 42		15. 00
16. 00	Certified Nursing Assistant/Nursing	227, 979		227, 979	5, 291. 58	43. 08	16. 00
47.00	Assi stants/Ai des					=0.04	47.00
17. 00	Total Nursing (sum of lines 14 through 16)	442, 040		442, 040	·		17. 00
18. 00	Physical Therapists	121, 084		121, 084	·		
19.00	Physical Therapy Assistants	9, 882		9, 882	234. 00		
20.00	Physical Therapy Aides	0		0	0.00		
21. 00	Occupational Therapists	120, 564		120, 564			21. 00
22. 00	Occupational Therapy Assistants	30, 319		30, 319	713. 00		22. 00
23. 00	Occupational Therapy Aides	54 40(0	0.00		23. 00
24. 00	Speech Therapists	51, 426		51, 426			
25. 00	Respiratory Therapists	307		307	6.00		25. 00
26. 00	Other Medical Staff	30, 114		30, 114	354.00	85.07	26. 00

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67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PE2 67. 00 PB2 69. 00 PD1 70. 00 PC2 71. 00 PC1 72. 00 PB2 73. 00 PB1 74. 00			
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71. 00 72. 00 73. 00 74. 00 PB1 71. 00 72. 00 73. 00 PB1 74. 00	69. 00	PD2	69. 00
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73. 00 74. 00 PB1 73. 00 74. 00		PC2	
74. 00 PB1 74. 00			
	74. 00	PB1	74.00
	75. 00		75. 00

Health Financial Systems	RI DGEWOOD CENTER		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Peri od:	Worksheet S-	7
			From 01/01/2021 To 12/31/2021	Date/Time Pro 5/19/2022 1::	
			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 payments beginning 10/01/2003. Congress expexpenses. For lines 101 through 106: Enter column 2 the percentage of total expenses f line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expens (See instructions)	ected this increase to be used in column 1 the amount of the for each category to total SNF for yes or "N" for no if the	d for direct p expense for e revenue from spending refle	aatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing					101. 00
102.00 Recruitment					102. 00
103.00 Retention of employees					103. 00
104. 00 Trai ni ng					104. 00
105. 00 OTHER (SPECIFY)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, I	ine 1, column 3)	1			106. 00

Health Financial Systems	RI DGEWOOD CE	ENTER		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	5/19/2022 1: 2 Reclassi fi ed	4 piii
oost denter beserretten	Sur ur r cs	o their	+ col . 2)	ons	Trial Balance	
			,	Increase/Decre	(col. 3 +-	
				ase (Fr Wkst	col. 4)	
	1.00		2.22	A-6)	5.00	
GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES		978, 346	978, 34	6 0	978, 346	1. 00
2. 00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT		0			0	2. 00
3. 00 00300 EMPLOYEE BENEFITS	0	586, 654	586, 65	4 0	586, 654	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	386, 174	1, 557, 173	1, 943, 34	7 0	1, 943, 347	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	61, 680	235, 907	297, 58	7 0	297, 587	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	0	180, 131	180, 13		180, 131	6. 00
7. 00 00700 HOUSEKEEPI NG	0	216, 361	216, 36		216, 361	7. 00
8. 00 00800 DI ETARY	207 (00	660, 449			660, 449	8. 00
9.00 00900 NURSI NG ADMI NI STRATI ON 10.00 01000 CENTRAL SERVI CES & SUPPLY	297, 680	23, 650 24, 753			273, 616	9.00
11. 00 01100 PHARMACY		24, 733 N	24, 75	15, 490	40, 243 0	10. 00 11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY		0		32, 224	32, 224	12.00
13. 00 01300 SOCI AL SERVI CE	122, 855	0	122, 85		122, 855	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	,	0	0	14.00
15. 00 01500 ACTIVITIES	120, 164	12, 475	132, 63	9 0	132, 639	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	2, 047, 983	548, 203	2, 596, 18	6 0	2, 596, 186	30. 00
31. 00 03100 NURSI NG FACILITY	0	0	(0	0	31. 00
32.00 03200 CF/IID 33.00 03300 OTHER LONG TERM CARE	0	0			0	32.00
33.00 O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	l U			0	0	33. 00
40. 00 04000 RADI OLOGY	0	15, 236	15, 23	6 0	15, 236	40. 00
41. 00 04100 LABORATORY		5, 114			5, 114	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	o	2, 033			2, 033	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	9, 478	9, 47	8 0	9, 478	43.00
44. 00 04400 PHYSI CAL THERAPY	0	145, 746	145, 74	6 0	145, 746	44. 00
45. 00 04500 OCCUPATIONAL THERAPY	0	119, 196			119, 196	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	71, 465	71, 46	5 0	71, 465	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0			0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49.00 04900 DRUGS CHARGED TO PATIENTS		94, 060	94, 060		0 94, 060	48. 00 49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY		94, 000	74, 00		94, 000	50. 00
51. 00 05100 SUPPORT SURFACES		48, 521	48, 52	1 0	48, 521	51. 00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		o o	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0	0	(0 0	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC	0	0	(0	0	61.00
62. 00 06200 FOHC 63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0			0	62. 00 63. 00
OTHER REIMBURSABLE COST CENTERS	l U			J 0	U	63.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71. 00 07100 AMBULANCE	o	0		o o	0	71. 00
72. 00 07200 CORF	0	0		О	0	72. 00
73. 00 07300 CMHC	0	0		0 0	0	73.00
74. 00 07400 OTHER REIMBURSABLE COST	0	0	(0 0	0	74. 00
SPECIAL PURPOSE COST CENTERS				ما ما		
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0	0	80. 00 81. 00
81. 00 08100 I NTEREST EXPENSE 82. 00 08200 UTI LI ZATI ON REVI EW		0			0	81.00
83. 00 08300 HOSPI CE		0			0	83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS	o	0			0	84. 00
89.00 SUBTOTALS (sum of lines 1-84)	3, 036, 536	5, 534, 951	8, 571, 48 ⁻	7 0	8, 571, 487	89. 00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0 0	0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP	0	0	(이	0	91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	'	0	0	92.00
93. 00 09300 NONPAI D WORKERS 94. 00 09400 PATI ENTS LAUNDRY		0	'		0	93. 00 94. 00
95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS		0			0	94. 00 95. 00
100.00 TOTAL	3, 036, 536	5, 534, 951	8, 571, 48	7 0	8, 571, 487	
•						,

RI DGEWOOD CENTER In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 RIDGE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

CERETAL SERVICE COST CENTERS					To 12/31/2021	Date/Time Prepared: 5/19/2022 1:24 pm
Windle A-80 Cool 5 Cool 5 Cool		Cost Center Description				37 177 2022 1. 24 piii
SINERAL SERVICE COST CENTERS						
CENERAL SERVICE COST CENTERS			WKST A-8)			
1.00 0.0100 CAP PEL COSTS - BLIDGS & FIXTURES 0 978.346 1.00 2.00			6.00		-	
2.00 00200 CAP RET COSTS - MOVABLE FOULPHENT 0 0 2.00		GENERAL SERVICE COST CENTERS				
3.00 03000 EMPLOYEE BENEFITS			0			
0.000 0.00			_		•	
DOBDO CHANT OPERATION, MAINT, & REPAIRS 0 297, 587 5 5 0		1 1		1	1	
7. 00 00 0700 MUSEKEEPING 0 216, 361 8. 00 9. 00 00900 MURSI NG ADMINI STRATION 0 273, 616 9. 00 9. 00 00900 MURSI NG ADMINI STRATION 0 273, 616 9. 00 11. 00 01000 ENTRAL SERVICES & SUPPLY 0 40, 243 10. 00 11. 00 01100 PHARMACY 0 32, 224 12. 00 12. 00 101300 SURCIVICA SERVICE 0 32, 224 12. 00 11. 00 101300 SURCIVICA SERVICE 0 122, 201 15. 00 10. 00 10300 ACTIVITIES 15. 00 15. 00 15. 00 10. 00 10300 ACTIVITIES 15. 00 15. 00 15. 00 10. 00 10300 ACTIVITIES 15. 00 15. 00 15. 00 11. 00 10300 ACTIVITIES 285 2.5 96, 471 31. 00 31. 00 3100 ACTIVITIES 285 2.5 96, 471 31. 00 31. 00 310 ACTIVITIES 2.5 96, 471 31. 00 31. 00 315, 236 <			0		1	
0.000 0.0000 DIETARY 0 6.60, 449 8.00 0.000 0.000 DIESARY 0 0.000 0.000 0.000 0.000 0.000 0.0000 0.			0	l .	1	
9. 00 00000 (MURSI IN SADMINI STRATION 0 273, 616 9. 00 11. 00 01000 (DITRICE SERVICE CEST SUPPLY 0 40, 243 10. 00 11. 00 01000 (DITRICE SERVICE CEST SERVICE 0 0 0 11. 00 13. 00 01300 (SOCIAL SERVICE 0 122, 855 13. 00 14. 00 15. 00 01500 (ACTIVITIES -10,618 122, 021 15. 00 14. 00 15. 00 01500 (ACTIVITIES -10,618 122, 021 30. 00 31. 00 30. 00 03000 (SIXI LLED MURSIN SERVICE COST CENTERS 30. 00 31. 00 33. 00 30. 00 03000 (SIXI LLED MURSIN SERVICE COST CENTERS 32. 00 31. 00 33. 00 30. 00 03000 (SIXI LLED MURSIN SERVICE COST CENTERS 32. 00 33. 00 33. 00 40. 00 03000 (SIXI LLED MURSIN SERVICE COST CENTERS 32. 00 33. 00 33. 00 40. 00 03000 (SIXI LLED MURSIN SERVICE COST CENTERS 32. 00 33. 00 33. 00 40. 00 0400 (MURSIN SERVICE COST CENTERS 32. 00 33. 00 </td <td></td> <td></td> <td>0</td> <td>l .</td> <td>1</td> <td></td>			0	l .	1	
10.00 01000 CENTRAL SERVICES & SUPPLY 0 40, 243 11.00 110.00		l l	0	l ·	1	
12.00 01200 MEDICAL RECORDS & LIBRARY 0 32.224 12.00 13.00 13.00 13.00 01300 SOCIAL SERVICE 0 122.855 13.3 00 14.00 01400 MURSING AND ALLIED IREALTH EDUCATION 0 0 0 0 14.00 15.00 1			0	l ·	1	
13. 00 01300 SOCIAL SERVI CE 0 122,855 13. 00 14. 00 15. 00		1 1	0		1	
14. 00 10-1400 NURSING AND ALLIED HEALTH EDUCATION 0 10, 00 10, 00 15. 0			0		1	
15. 00			0		1	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 331.00 331.00 331.00 331.00 331.00 331.00 331.00 331.00 332.00 333.00 INJERS ING FACILITY 0 0 0 32.00 333.00 333.00 CHERL LONG TERM CARE 0 0 0 32.00 330.00 330.00 331			-10, 618		1	
31.00 03100 NURSIN F FACILITY			,	.==, ==.		
32.00 03200 CFF I I D					1	
33.00 03300 OTHER LONG TERM CARE 0 0 0 33.00			0		•	
ANCILLARY SERVICE COST CENTERS 40.00		l l	0	l .	1	
41.00 04100 LABORATORY 0 5, 114 41.00 42.00 42.00 04200 INTRAVENOUS THERAPY 0 2, 033 42.00 43.00 04300 DAYCEN (I HHALATION) THERAPY 0 9, 478 43.00 44.00 04400 PHYSICAL THERAPY 0 115, 746 44.00 44.00 44.00 04500 OCCUPATIONAL THERAPY 0 119, 196 45.00 46.00 04600 SPEECH PATHOLOGY 0 71, 465 46.00 47.00 470.00 4	00.00				1	33. 33
42.00 04200 INTRAVENDUS THERAPY 0 2.033 42.00 43.00 04300 0XYCEN (INMALATION) THERAPY 0 9.478 43.00 04300 0XYCEN (INMALATION) THERAPY 0 1145.746 44.00 44.00 04400 PHYSI CAL THERAPY 0 119.196 45.00 04500 0CCUPATI ONAL THERAPY 0 119.196 45.00 45.00 04600 SPEECH PATHOLOGY 0 71.465 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0	40.00	04000 RADI OLOGY	0	15, 236		40.00
43. 00 44.00 04/00 PAYSCEN (INHALATION) THERAPY 0 9, 478 44. 00 44.00 04/00 PHYSICAL THERAPY 0 119, 196 45. 00 45. 00 45. 00 45. 00 45. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 47. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 50.		l l	0			
44.00 04400 PHYSICAL THERAPY 0 145, 746 45.00 45.00 04500 OCCUPATIONAL THERAPY 0 119, 196 45.00 46.00 04600 SPECH PATHOLOGY 0 71, 465 46.00 047.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0		l l	0		1	
45.00 04500						
47. 00 04700 04700 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		I I	0	1	1	
48. 00 04900 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 94,060 49. 00 50. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 94,060 50. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 52. 00 05000 OTHER ROLILLARY SERVICE COST CENTERS 0 0 0 0 00100 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 60. 00 06000 CLIN IC 0 0 0 0 0 0 0 0 61. 00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 62. 00 62. 00 06200 FOHC 0 63. 00 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0	71, 465		
49.00 04900 DRUGS CHARGED TO PATLENTS			0	1	1	
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0	_		
51.00 05100 SUPPORT SURFACES 0 48,521 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0					1	
OUTPAT I STENUICE COST CENTERS O			0	48, 521		
60. 00 06000 CLINIC 0 0 0 0 0 0 0 0 0	52. 00		0	0		52. 00
61. 00	(0.00				N.	40.00
62. 00 06200 FOHC 0 0 0 0 0 0 0 0 0		l l	_		•	
OTHER REIMBURSABLE COST CENTERS						
70. 00	63.00		0	0		63. 00
71. 00	70.00		1	1	J	70.00
72.00			0	_	•	
73. 00				0		
SPECIAL PURPOSE COST CENTERS SO. 00 O O O O			0	0		
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 0 0 0 0 81. 00 81. 00 82. 00 08200 UTI LI ZATI ON REVI EW 0 0 0 82. 00 83.	74. 00		0	0)	74. 00
81. 00	00.00					00.00
82. 00 82.00 08200 UTI LI ZATI ON REVIEW 0 0 0 82.00 83.00 84.00 84.00 84.00 84.00 84.00 84.00 84.00 84.00 85.00 84.00 8			0		•	
84. 00 89. 00 89. 00 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 91. 00 91. 00 92. 00 93. 00 93. 00 94. 00 94. 00 95. 00 96. 00 97. 00		l l	Ö		1	
89. 00 SUBTOTALS (sum of lines 1-84)			0	0		
NONRE MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0		I I	0	0		
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0	89.00		- 709, 928	7, 861, 559	1	89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 91. 00 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 93. 00 94. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0	90. 00		0	0		90.00
93. 00 09300 NONPAI D WORKERS 0 0 0 94.00 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 95.00 09500 0			0		•	
94. 00 09400 PATIENTS LAUNDRY 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 95. 00 0 0 0 0 0 0 0 0 0		l l	0	0)	
95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 95. 00			0	0		
			0	0		
			-709, 928	7, 861, 559		

Health Financial Systems	RIDGEWOOD CENTER	?		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Pr	rovi der N		Period: From 01/01/2021	Worksheet A-6	
				To 12/31/2021	Date/Time Prep 5/19/2022 1: 2	
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3. 00	4. 00	5. 00	
(1) A - DEFAULT						
1.00	CENTRAL SERVICES & SU	PPLY	10. 0	15, 490	0	1.00
2. 00	MEDICAL RECORDS & LIB	RARY	12. 0	32, 224	0	2.00
TOTALS						
100. 00	Total Reclassificatio	ns (Sum		47, 714	0	100.00
	of columns 4 and 5 mu	st				
	equal sum of columns	8 and				
	9)					

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

Health Financial Systems	RI DGEWOOD CENTER	3		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Р	rovi der		Period: From 01/01/2021	Worksheet A-6	
				To 12/31/2021	Date/Time Pre 5/19/2022 1:2	pared: 4 pm
			Decreases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
(1) A - DEFAULT						
1.00	NURSING ADMINISTRATIO	N	9. 00	15, 490	0	1.00
2. 00	NURSING ADMINISTRATIO	N	9. 00	32, 224	0	2.00
TOTALS						
100. 00				47, 714	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RI DGEWOOD CENTER In Lieu of Form CMS-2540-10 Provider No.: 315158 | Period: | Worksheet A-7 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				10	12/31/2021	5/19/2022 1:24	
				Acqui si ti ons		07 177 2022 1: 2	T DIII
	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 BALANCES	S					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	27, 876	26, 469	0	26, 469	[0	2.00
3.00	Buildings and Fixtures	0	0	0	0	[0	3. 00
4.00	Building Improvements	425, 941	2, 225	0	2, 225		4. 00
5.00	Fi xed Equi pment	53, 626	36, 117	0	36, 117		5. 00
6.00	Movable Equipment	403, 846	11, 920	0	11, 920		6. 00
7.00	Subtotal (sum of lines 1-6)	911, 289	76, 731	0	76, 731	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	911, 289	76, 731	0	76, 731	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
	TANALYSIS OF SURVISES IN SARITAL ASSET BALANCE	6.00	7. 00				
4 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						4 00
1.00	Land	0	0				1.00
2.00	Land Improvements	54, 345	0				2. 00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	428, 166	0				4. 00
5.00	Fi xed Equi pment	89, 743	0				5.00
6.00	Movable Equipment	415, 766	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	988, 020	0				7. 00
8. 00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	988, 020	0				9. 00

Peri od: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				To 12/31/2021	Date/Time Pre 5/19/2022 1: 2	
				Expense Classification on		4 pili
				To/From Which the Amount is		
				To Trom Willer the Amount 13	to be hajusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	, ,	Adjustment				
		1.00	2.00	3. 00	4.00	
1. 00	Investment income on restricted funds		0		0.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)	A	-10, 618	ACTI VI TI ES	15. 00	
7.00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
	Capital expenditures (chapter 24)					
12. 00	Adjustment resulting from transactions with	A-8-1	-27, 220)		12.00
	related organizations (chapter 10)					
13. 00	Laundry and linen service		0			13. 00
14. 00	Revenue - Employee meals		0	1		14. 00
15. 00	Cost of meals - Guests		0	1	0.00	
16. 00	Sale of medical supplies to other than		0)	0.00	16. 00
47.00	patients					47.00
17. 00	Sale of drugs to other than patients		0		0.00	
18.00	Sale of medical records and abstracts		0	1	0.00	
19. 00	Vendi ng machi nes		0	2	0.00	
20. 00	Income from imposition of interest, finance		0)	0.00	20. 00
21 00	or penalty charges (chapter 21)		0		0.00	21. 00
21. 00	Interest expense on Medicare overpayments		U	1	0.00	21.00
	and borrowings to repay Medicare overpayments					
22. 00	Utilization reviewphysicians' compensation		_	UTILIZATION REVIEW	82.00	22. 00
22.00	(chapter 21)		U	OTTELZATION REVIEW	02.00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1 00	23. 00
23.00	bepreciationburidings and fixtures			FIXTURES	1.00	23.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
24.00	Depi cei ati onillovabi e equi pilient			EQUI PMENT	2.00	24.00
25. 00	MISC INCOME	В	_17 065	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 00	UNALLOWED A & G	A		ADMINISTRATIVE & GENERAL		25. 00
25. 01	WORKERS COMPENSATION	A		EMPLOYEE BENEFITS	3.00	
	HEP/SALINE	A		SKILLED NURSING FACILITY	30.00	
	Total (sum of lines 1 through 99) (Transfer	^	-709, 928	1	30.00	100.00
100.00	to Worksheet A, col. 6, line 100)		-107, 720	[100.00
(1) D-	assistics all charter references in this co	lump postoin to	CMC Dub 1F 1	1 1	1	1

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

⁽²⁾ Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

RIDGEWOOD CENTER

Heal th Financial Systems RIDGEWOOD OF STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS Provi der No.: 315158

OFFICE COSTS				o 12/31/2021	Date/Time Pre	
	Li ne No.	Cost (Center	Expense	5/19/2022 1:2 Items	24 pm
	1.00	2.	00	3. 0	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6. line 100 to Worksheet A-8, column 3, line	4. 00 44. 00 45. 00 46. 00 30. 00 43. 00	ADMI NI STRATI VE ADMI NI STRATI VE PHYSI CAL THERA OCCUPATI ONAL T SPEECH PATHOLO SKI LLED NURSI N OXYGEN (I NHALA ADMI NI STRATI VE	& GENERAL PY HERAPY GY G FACILITY TION) THERAPY	HOME OFFICE A&G HOME OFFICE CAP PT OT ST NURSING PURCHAS RT MEDICAL DIRECTO	PITAL SED SERVICES	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
12.	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE		OR	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line	429, 064 26, 443 143, 764 119, 196 71, 465 442, 040 8, 977 30, 114 0 1, 271, 063	482, 727 0 143, 764 119, 196 71, 465 442, 040 8, 977 30, 114 0 1, 298, 283	26, 443 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

				5/19/2022 1: 24	4 pm
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
DART II INTERRE ATLANGUER TO BELATER ORGANIE	7.4.T.L. ONL (O)	D HOME OFFI OF			

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

	Rel ated Organi	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDE ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6. 00

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2. 00		GRS	100.00	PT OT ST	2.00
3. 00		GSS	100.00	NURSING PURCHASED SERVICES	3.00
4.00		RHS	100.00	RT	4.00
5.00		GPS	100.00	MEDICAL DIRECTOR	5. 00
6. 00			0.00		6.00
7. 00			0.00		7.00
8. 00			0.00		8.00
9. 00			0.00		9.00
10. 00			0.00		10.00
100.00 G. Other (fin	ancial or non-financial)		0.00		100. 00
speci fy:					

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

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			To	o 12/31/2021	Date/Time Pre	
		CAPITAL REL	ATED COSTS		5/19/2022 1: 2	4 pm
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	col. 7)	1. 00	2. 00	3. 00	3A	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS - BLDGS & FIXTURES 2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 3. 00 00300 EMPLOYEE BENEFITS 4. 00 00400 ADMINISTRATIVE & GENERAL 5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	978, 346 0 597, 981 1, 232, 425 297, 587	978, 346 7, 116 24, 716 38, 771	0 0	605, 097 76, 954 12, 291	1, 334, 095 348, 649	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00	180, 131 216, 361 660, 449 273, 616 40, 243	40, 572 50, 317 60, 180 0 35, 759	0 0 0	0 0 0 49, 811 3, 087	220, 703 266, 678 720, 629 323, 427 79, 089	6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 01100 PHARMACY 12. 00 01200 MEDICAL RECORDS & LIBRARY 13. 00 01300 SOCIAL SERVICE 14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	32, 224 122, 855 0	5, 737 0 5, 935 2, 480 0	0 0	0 6, 421 24, 482 0	44, 580 149, 817 0	11. 00 12. 00 13. 00 14. 00
15. 00 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	122, 021	18, 987	0	23, 945	164, 953	15. 00
30. 00 03000 SKILLED NURSING FACILITY 31. 00 03100 NURSING FACILITY 32. 00 03200 ICF/IID 33. 00 03300 OTHER LONG TERM CARE	2, 596, 471 0 0 0	654, 949 0 0 0	0 0 0 0	408, 106 0 0 0	3, 659, 526 0 0 0	30. 00 31. 00 32. 00 33. 00
ANCI LLARY SERVI CE COST CENTERS 40. 00 O4000 RADI OLOGY	15, 236	0	0	0	15, 236	40. 00
41. 00	5, 114 2, 033 9, 478	0 0	0	0 0	5, 114 2, 033 9, 478	41. 00 42. 00 43. 00
44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 0CCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	145, 746 119, 196 71, 465	11, 900 10, 099 6, 319	0 0	0 0 0	157, 646 129, 295 77, 784 0	44. 00 45. 00 46. 00 47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES 52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	94, 060 94, 521 0	3, 691 6, 555 0 0	0 0 0	0 0 0 0	3, 691 100, 615 0 48, 521	48. 00 49. 00 50. 00 51. 00 52. 00
OUTPATIENT SERVICE COST CENTERS	J	<u> </u>	<u> </u>	<u> </u>	0	02.00
60. 00 06000 CLINIC 61. 00 06100 RURAL HEALTH CLINIC 62. 00 06200 FOHC 63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0 0	0 0 0	0 0	0 0 0	0 0	60. 00 61. 00 62. 00 63. 00
0THER REI MBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 71. 00 07100 AMBULANCE 72. 00 07200 CORF 73. 00 07300 CMHC 74. 00 07400 OTHER REI MBURSABLE COST	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	70. 00 71. 00 72. 00 73. 00 74. 00
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	80. 00 81. 00 82. 00 83. 00 84. 00
89.00 SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	7, 861, 559	978, 346	0	605, 097	7, 861, 559	89. 00 90. 00
91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSICIANS PRIVATE OFFICES 93. 00 09300 NONPALD WORKERS 94. 00 09400 PATIENTS LAUNDRY 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 98. 00 Cross Foot Adjustments	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	91. 00 92. 00 93. 00 94. 00 95. 00 98. 00
99.00 Negative Cost Centers 100.00 TOTAL	0 7, 861, 559	0 978, 346	0	0 605, 097	0 7, 861, 559	99. 00 100. 00

					o 12/31/2021		pared:
	Cost Center Description ADMI		PLANT	LAUNDRY &	HOUSEKEEPI NG	5/19/2022 1: 2 DI ETARY	4 pm
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. & REPAIRS				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	1, 334, 095					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	71, 258	419, 907	·			5.00
6.00	00600 LAUNDRY & LINEN SERVICE	45, 108	18, 768				6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG	54, 504	23, 276		344, 458	021 120	7. 00 8. 00
9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	147, 284 66, 103	27, 838 0		25, 377 0	921, 128 0	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	16, 164	16, 542	o o	15, 079		10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	9, 111	2, 746		2, 503	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	30, 620	1, 147		1, 046	0	13. 00 14. 00
15. 00	01500 ACTIVITIES	33, 713	8, 783	1	8, 007	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	2275	27.122	-	2, 22.1		
30.00	03000 SKILLED NURSING FACILITY	747, 939	302, 968	284, 579	276, 184	921, 128	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0	1		0	32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	ı o		,, 0	0	0	33.00
40.00	04000 RADI OLOGY	3, 114	0	0	0	0	40.00
41. 00	04100 LABORATORY	1, 045	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	416	0	0	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	1, 937 32, 220	5, 505	0	0 5, 018	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	26, 426	4, 672	1		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	15, 898	2, 923			0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	754	1, 707	1	.,	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	20, 564	3, 032		2, 764	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	9, 917	0		0	0	51. 00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS	T					
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	1		0	60. 00 61. 00
62. 00	06200 FQHC	U U	U	,	U	U	62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 72. 00	07100 AMBULANCE 07200 CORF	0	0		0	0	71. 00 72. 00
	07300 CMHC		0	Ö	0	0	73. 00
	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS						
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00 81. 00
81.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81.00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 334, 095	419, 907	284, 579	344, 458	921, 128	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	0	O	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		-	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0	o o	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0			0	95. 00 98. 00
99. 00	Negative Cost Centers		Ö	Ö	O	0	99. 00
100.00		1, 334, 095	419, 907	284, 579	344, 458	921, 128	100. 00

						0 12/31/2021	5/19/2022 1: 2	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
			ADMI NI STRATI ON	SERVICES &		RECORDS &		
			2.00	SUPPLY	44.00	LIBRARY	10.00	
	CENED	AL CEDIU OF COCT CENTEDS	9. 00	10. 00	11. 00	12. 00	13. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00		CAP REL COSTS - BEDGS & TEXTORES CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	1	EMPLOYEE BENEFITS						3.00
4. 00	1	ADMINISTRATIVE & GENERAL						4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS						5.00
6. 00	1	LAUNDRY & LINEN SERVICE						6.00
7. 00		HOUSEKEEPING						7. 00
8.00	00800	DI ETARY					!	8. 00
9.00		NURSING ADMINISTRATION	389, 530					9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	126, 874				10. 00
11. 00	1	PHARMACY	0	0	()		11. 00
12.00	1	MEDICAL RECORDS & LIBRARY	0	0	(58, 940		12.00
13.00	1	SOCIAL SERVICE	0	0	9	0	182, 630	1
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0	9		0	
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	l U	0	() 0	0	15. 00
30. 00		SKILLED NURSING FACILITY	389, 530	126, 874		52, 972	182, 630	30.00
31. 00		NURSING FACILITY	307, 330	120, 074	l		102, 030	31.00
32. 00	1	ICF/IID		0				32.00
33. 00	1	OTHER LONG TERM CARE	o	0	•		Ö	ł
		LARY SERVICE COST CENTERS			•	1		
40.00	04000	RADI OLOGY	0	0	(88	0	40. 00
41. 00	1	LABORATORY	0	0	(0	
42. 00		INTRAVENOUS THERAPY	0	0	(21	0	42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0	(1	0	43.00
44. 00	1	PHYSI CAL THERAPY	0	0	9	2, 159		44. 00
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		2,036		45. 00 46. 00
46.00		ELECTROCARDI OLOGY	0	0)	1, 017		47.00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48.00
49. 00	1	DRUGS CHARGED TO PATIENTS		0		563	-	49. 00
50. 00		DENTAL CARE - TITLE XIX ONLY		0		0		50.00
51. 00		SUPPORT SURFACES	o	0		3	Ö	51.00
52.00	1	OTHER ANCILLARY SERVICE COST CENTERS	O	0	(0	0	52. 00
	OUTPA ⁻	TIENT SERVICE COST CENTERS						
60.00		CLI NI C	0	0	(0	60. 00
61. 00		RURAL HEALTH CLINIC	0	0	(0	0	61.00
62.00	06200			Ō				62.00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	63. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	O	0		0	0	70. 00
71.00		AMBULANCE		0				71.00
72.00	07200			0			٥	72.00
73. 00	07300		o	0		Ö	Ö	73. 00
74.00	1	OTHER REIMBURSABLE COST	o	0		0	0	74. 00
	SPECIA	AL PURPOSE COST CENTERS						
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	1	INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW						82. 00
83. 00		HOSPI CE	0	0			0	•
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	200 520	127 074			102 (20	84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	389, 530	126, 874		58, 940	182, 630	89. 00
90. 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0) 0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP		0				91.00
92. 00		PHYSICIANS PRIVATE OFFICES		0	l			•
93. 00		NONPALD WORKERS		0	1	o o	Ö	
94. 00		PATI ENTS LAUNDRY	0	0		o o	O	•
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	o	0		0	0	95. 00
98. 00		Cross Foot Adjustments	0	0				98. 00
99. 00		Negative Cost Centers	0	0	(0	
100.00)	TOTAL	389, 530	126, 874		58, 940	182, 630	100. 00

 FER
 In Lieu of Form CMS-2540-10

 Provider No.: 315158
 Period: From 01/01/2021 | Part I | Prepared: To 12/31/2021 | Part I | Part

						To 12/31/2021	Date/Time Pre 5/19/2022 1:2	
				OTHER GENERAL			37 177 2022 1.2	T pill
				SERVI CE				
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
			EDUCATION			Auj us tillerits		
			14. 00	15.00	16.00	17. 00	18. 00	
		AL SERVICE COST CENTERS	T	T	Т	T	T	
1.00	1	CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS						2. 00 3. 00
4. 00		ADMINISTRATIVE & GENERAL						4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	1	LAUNDRY & LINEN SERVICE						6. 00
7.00		HOUSEKEEPI NG						7. 00
8. 00 9. 00		DI ETARY NURSI NG ADMINI STRATI ON		•				8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY						10.00
11. 00	1	PHARMACY						11. 00
12.00	01200	MEDICAL RECORDS & LIBRARY						12. 00
13.00		SOCIAL SERVICE						13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0	045 45				14. 00
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	0	215, 456	P[15. 00
30. 00		SKILLED NURSING FACILITY		215, 456	7, 159, 78	6 0	7, 159, 786	30.00
31. 00		NURSING FACILITY	0	2.07.00	1	o o	0	31. 00
32.00	03200	ICF/IID	0	C		0 0	0	32. 00
33. 00		OTHER LONG TERM CARE	0	C		0 0	0	33. 00
40.00		LARY SERVICE COST CENTERS			10 42	0 0	10 420	40.00
40. 00 41. 00	1	RADI OLOGY LABORATORY	0		1		18, 438 6, 239	
42. 00		INTRAVENOUS THERAPY			2, 47		2, 470	
43.00		OXYGEN (INHALATION) THERAPY	0	C	11, 41		11, 416	
44. 00	1	PHYSI CAL THERAPY	0	C	202, 54		202, 548	
45. 00		OCCUPATIONAL THERAPY	0				166, 688	
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0		100, 28	0 0	100, 287 0	1
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS			1	٥	7, 708	1
49. 00		DRUGS CHARGED TO PATIENTS	0	C	1		127, 538	
50.00		DENTAL CARE - TITLE XIX ONLY	0	C	1	0 0	0	50. 00
51.00		SUPPORT SURFACES	0				58, 441	
52. 00		OTHER ANCILLARY SERVICE COST CENTERS TIENT SERVICE COST CENTERS	0	C	<u>/ </u>	0 0	0	52.00
60.00		CLINIC	0			0 0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	C		0 0		61. 00
62. 00	06200		_				_	62.00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	0	()	0 0	0	63.00
70. 00		HOME HEALTH AGENCY COST	0			o o	0	70. 00
71.00		AMBULANCE	0	C	1	0 0	0	1
72. 00	07200		0	C		0 0	0	
73.00			0	C		0	0	
74.00	SDECT	OTHER REIMBURSABLE COST AL PURPOSE COST CENTERS	0		<u>/ </u>	0 0	0	74. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	1	INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW						82. 00
83.00		HOSPI CE	0	C		0	0	
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	215 454	7 041 55	0 0	7 041 550	
69.00	NONRE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS		215, 456	7, 861, 55	9 0	7, 861, 559	09.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0 0	0	90.00
91. 00	1	BARBER AND BEAUTY SHOP	0	C		0 0	0	
92.00		PHYSICIANS PRIVATE OFFICES	0	C		0	0	
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY)	0	0	
94. 00 95. 00		OTHER NONREIMBURSABLE COST CENTERS			ó	0 0	0	1
98. 00		Cross Foot Adjustments				o o	ő	
99. 00		Negative Cost Centers	0	C		0 0	0	
100.00)	TOTAL	0	215, 456	7, 861, 55	9 0	7, 861, 559	100. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315158

				To	12/31/2021	Date/Time Pre 5/19/2022 1:2	
			CAPITAL RELATED COSTS			3/14/2022 1.2	4 piii
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	oust defiter beset percit	Assigned New	FIXTURES	EQUI PMENT	Subtotal	BENEFI TS	
		Capi tal					
		Related Costs 0	1. 00	2. 00	2A	3. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS	0	7, 116	0	7, 116	7, 116	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	24, 716	0	24, 716	905	4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	38, 771 40, 572	0	38, 771 40, 572	145 0	5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	0	50, 317	0	50, 317	0	7. 00
8.00	00800 DI ETARY	0	60, 180	0	60, 180	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	586	1
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	35, 759 0	0	35, 759 0	36 0	10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	O	5, 935	Ö	5, 935	76	12. 00
13. 00	· · · · · · · · · · · · · · · · · · ·	0	2, 480		2, 480	288	
14. 00 15. 00	+ I	0	0 18, 987	0	0 18, 987	0 282	14. 00 15. 00
13.00	I NPATIENT ROUTINE SERVICE COST CENTERS	J O	10, 707	Į	10, 707	202	13.00
30.00	03000 SKILLED NURSING FACILITY	0	654, 949	0	654, 949	4, 798	1
31. 00		0	0	0	0	0	31.00
32. 00 33. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	32. 00 33. 00
00.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		91			00.00
40. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	41. 00 42. 00
43. 00	+ I	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	11, 900	0	11, 900	0	44. 00
45. 00		0	10, 099		10, 099	0	45. 00
46. 00 47. 00		0	6, 319 0	0	6, 319 0	0	46. 00 47. 00
48. 00	1	o	3, 691	o	3, 691	0	48. 00
49. 00		0	6, 555	0	6, 555	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 ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS						
60.00		0	0	0	0	0	60.00
61. 00 62. 00	+ I	0	U	0	O	0	61. 00 62. 00
63. 00	1 1	0	0	0	0	0	
	OTHER REIMBURSABLE COST CENTERS	_	-		_	_	
70. 00 71. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	70. 00 71. 00
	07200 CORF	0	0	0	0	0	
73. 00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	T					80.00
81. 00							81.00
82. 00							82.00
83. 00 84. 00		0	0	0	0	0	83. 00 84. 00
89. 00		o	978, 346	_	978, 346	7, 116	
	NONREI MBURSABLE COST CENTERS						
90. 00 91. 00		0	0	0	0	0	
92. 00		0	0	0	0	0	
93. 00	09300 NONPALD WORKERS	O	o	o	0	0	93. 00
94.00	1	0	0	0	0	0	
95. 00 98. 00			O I		0	0	95. 00 98. 00
99. 00			0	О	0	0	
100.00	D TOTAL	o	978, 346	o	978, 346	7, 116	100. 00

				1	0 12/31/2021	5/19/2022 1:2	
	Cost Center Description ADM		PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, p
	•	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS	25 (21					3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	25, 621	40 204				4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 368 866	40, 284 1, 801				6.00
7. 00	00700 HOUSEKEEPING	1, 047	2, 233	1	53, 597		7. 00
8. 00	00800 DI ETARY	2, 828	2, 233	1	3, 949	69, 628	8. 00
9. 00	00900 NURSING ADMINISTRATION	1, 269	2,071	1	3, 747	07, 020	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	310	1, 587	1	2, 346	0	10.00
11. 00	01100 PHARMACY	0	., 55,	0	2, 3.0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	175	263	ō	389	0	12. 00
13.00	01300 SOCIAL SERVICE	588	110		163	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	o	0	14. 00
15.00		647	843	0	1, 246	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	14, 368	29, 065	43, 239	42, 973	69, 628	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200 CF/IID	0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	60	0	1	0	0	40. 00
41. 00	1	20	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	8	0	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	37	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	619	528		781	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	507	448		663	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	305	280 0	1	415	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	14	164	1	242	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	395	291	1	430	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	271	i .	130	0	50.00
51. 00	05100 SUPPORT SURFACES	190	0	0	ol	0	51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	o o	ol	0	52. 00
	OUTPATIENT SERVICE COST CENTERS		_		·		
60.00	06000 CLI NI C	0	C	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	o	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						
70. 00		0	0	0	=	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72. 00	07200 CORF	0	0	0	0	0	72.00
73. 00		0	Ü	0	0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST	0) 0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS						00 00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW						82.00
83. 00	1	0	0		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0			0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	25, 621	40, 284	43, 239	53, 597	69, 628	89. 00
07.00	NONREI MBURSABLE COST CENTERS	25, 021	70, 201	75, 257	33, 377	07, 020	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	ol	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	o o	ol	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	O	o	o	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	o o	ol	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	o	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	95. 00
98. 00	Cross Foot Adjustments			0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	25, 621	40, 284	43, 239	53, 597	69, 628	100. 00

				To	12/31/2021	Date/Time Pre 5/19/2022 1: 2	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	T DIII
	·	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LIBRARY		
	CENEDAL CEDVICE COCT CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - BEDGS & FIXTURES						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	1, 855					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	40, 038				10.00
11. 00	01100 PHARMACY	0	0	0			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	6, 838		12.00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	3, 629	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTIVITIES	0	0	0	0	0	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 055	40.020	O	(147	3. 629	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	1, 855	40, 038 0	0	6, 147	3, 629	30. 00 31. 00
32. 00	03200 CF/IID		0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		0	0	0	0	33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS	١	<u> </u>	5	<u> </u>	U	33.00
40. 00	04000 RADI OLOGY	0	ol	0	10	0	40. 00
41.00	04100 LABORATORY	0	O	0	9	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	o	0	2	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	0	251	0	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	236	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	118	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	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	65	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES		0	0	0	0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	0	52. 00
32.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	O ₁	<u> </u>	0	32.00
60.00	06000 CLINIC	O	O	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	o	o	0	Ö	0	61. 00
62.00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	o	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72. 00	07200 CORF	0	0	0	0	0	72. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	l 0	U	U	U	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 HOSPI CE	0	o	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	О	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 855	40, 038	0	6, 838	3, 629	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments		O ₁	0	٥	0	95. 00 98. 00
98.00	Negative Cost Centers		0	0	Λ	0	98. 00 99. 00
100.00		1, 855	40, 038	0	6, 838		100.00
32.30	1 2	., 2001	,	١	-, -00		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

 Feet
 In Lieu of Form CMS-2540-10

 Provider No.: 315158
 Period: From 01/01/2021
 Worksheet B Part II

 To 12/31/2021
 Date/Time Prepared:

					To 12/31/2021	Date/Time Pre	
			OTHER GENERAL			5/19/2022 1:2	4 pm
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
		ALLIED HEALTH EDUCATION			Adj ustments		
		14. 00	15. 00	16.00	17.00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 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 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8.00
9. 00 10. 00	00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9. 00 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	22, 005	이			15. 00
30. 00	03000 SKILLED NURSING FACILITY	1 0	22, 005	932, 69	04 0	932, 694	30.00
31. 00	03100 NURSING FACILITY	0		.	0 0	0	31.00
32. 00	03200 CF/IID	0	l .	o	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		n -	0 0	70	40. 00
41. 00	04100 LABORATORY			1	.9 0		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	d		0 0	10	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	() 3	0	37	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	(14, 07		14, 079	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0		11, 95		11, 953	ı
47. 00	04700 ELECTROCARDI OLOGY			7, 43	0	7, 437 0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		4, 11	-	4, 111	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	(7, 73	66 0	7, 736	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	(O .	0	0	50.00
51.00	05100 SUPPORT SURFACES	0		19		190	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0		<u> </u>	0 0	0	52. 00
60. 00	06000 CLINIC	0			0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	(o	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
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	1 0			0 0	0	70.00
71. 00	07100 AMBULANCE	0			0 0	Ö	71.00
72. 00	07200 CORF	0	(o	0	0	72. 00
	07300 CMHC	0	l .		0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0		0	0 0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			1			80.00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 H0SPI CE	0	(0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0		070.04	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	22, 005	5 978, 34	-6 0	978, 346	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	(o	0 0	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	(O	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	(0	0	93.00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS				0	0	94. 00 95. 00
95. 00 98. 00	Cross Foot Adjustments			ől	0 0	0	98.00
99. 00	Negative Cost Centers	0			o o	0	99.00
100.00		0	22, 005	978, 34	6 0	978, 346	

				Т	o 12/31/2021	Date/Time Pre 5/19/2022 1:2	
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1. 00	2.00	SALARI ES) 3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	48	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	33, 132	l				1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	241	33, 132 241	ı			2. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	837	837			6, 527, 464	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 313	l	61, 680		348, 649	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 374	l	l .	C	220, 703	6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	1, 704 2, 038	l	l .		266, 678 720, 629	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	2,038	2,038			323, 427	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	1, 211	1, 211	15, 490		79, 089	•
	01100 PHARMACY	0	0	C	,	0	11.00
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	201	201 84	1		44, 580 149, 817	12. 00 13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	ł	1		1	14.00
	01500 ACTIVITIES	643	643	120, 164	i c	164, 953	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	22, 180	22, 180	2, 047, 983		3, 659, 526 0	30. 00 31. 00
32. 00	03200 ICF/IID	0	0	1	ή	1	32.00
	03300 OTHER LONG TERM CARE	0	Ō	1		0	33. 00
	ANCILLARY SERVICE COST CENTERS	_	_	1			
	04000 RADI OLOGY 04100 LABORATORY	0	1	1			40. 00 41. 00
41.00	04200 I NTRAVENOUS THERAPY					2, 033	
	04300 OXYGEN (INHALATION) THERAPY	0	Ö	Č		9, 478	
	04400 PHYSI CAL THERAPY	403	403	1	0	157, 646	ı
	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	342	l	l .		129, 295	1
46. 00 47. 00	04700 ELECTROCARDI OLOGY	214	214	1		77, 784 0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	125		· ·		3, 691	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	222	222	1	0	100, 615	
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			0	50.00
51. 00 52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0				48, 521 0	51. 00 52. 00
	OUTPATIENT SERVICE COST CENTERS		·				
	06000 CLI NI C	0	0	1		-	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	C) C	0	61. 00 62. 00
	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0			0	63.00
	OTHER REIMBURSABLE COST CENTERS		· · · · · ·				
	07000 HOME HEALTH AGENCY COST	0	0	1			70. 00
	07100 AMBULANCE 07200 CORF	0	0	C		0	71. 00 72. 00
	07300 CMHC		0			0	73.00
	07400 OTHER REIMBURSABLE COST	0	0	d		0	74. 00
	SPECIAL PURPOSE COST CENTERS	T	Г	T		T	
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	0	c	C	0	83.00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	84.00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	33, 132	33, 132	3, 036, 536	-1, 334, 095	6, 527, 464	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 0	0			0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	c	C	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92.00
93. 00 94. 00	09300 NONPALD WORKERS 09400 PATIENTS LAUNDRY	0	0			0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		0				95.00
98. 00	Cross Foot Adjustments		_				98. 00
99. 00	Negative Cost Centers						99. 00
102.00	Cost to be allocated (per Wkst. B,	978, 346	0	605, 097	'	1, 334, 095	102. 00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	29. 528734	0. 000000	0. 199272	2	0. 204382	103. 00
104.00	Cost to be allocated (per Wkst. B,		1. 555500	7, 116		25, 621	
465 -	Part II)						405 -
105. 00	Unit cost multiplier (Wkst. B, Part			0. 002343	5	0. 003925	105. 00
	1117	1	I	I .	I	I	I

Period: Worksheet B-1 From 01/01/2021 Date/Time Prepared: 5/19/2022 1:24 pm

				''	0 12/31/2021	5/19/2022 1: 2	
	Cost Center Description	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE (TOTAL PATIENT		DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON	, ,,,,,,
		REPAI RS	DAYS)			(TOTAL PATIENT	
		(SQUARE FEET) 5.00	6. 00	7. 00	8. 00	DAYS) 9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	30, 741		•			5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 374	l .				6. 00
7.00	00700 HOUSEKEEPI NG	1, 704	0	27, 663			7. 00
8.00	00800 DI ETARY	2, 038	0	2, 038	72, 003	1	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	24, 001	9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	1, 211	0	1, 211 0	0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	201		201	0		12. 00
13. 00	01300 SOCI AL SERVI CE	84	l .	84	0	ő	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	0	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	643	0	643	0	0	15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				70.000		
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	22, 180	24, 001	22, 180	72, 003	24, 001	30. 00 31. 00
32. 00	03200 CF/IID		1	0	0		32.00
33. 00	03300 OTHER LONG TERM CARE				0	1	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	C	-	_	0	-	40. 00
41. 00	04100 LABORATORY	C			0	1	41.00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY		1	0	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	403	-	403	0		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	342	l .	342	0	ő	45. 00
46.00	04600 SPEECH PATHOLOGY	214	l .	214	0	0	46. 00
47. 00		C	1	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	125	1		0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	222	1	222	0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES			0	0		51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	d		_	0	Ö	52. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	C	l .			0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	C	0	0	0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER		o	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	C	0	0	0	0	71. 00
	07200 CORF 07300 CMHC		0	0	0	0	72. 00 73. 00
	07400 OTHER REIMBURSABLE COST			0	Ü	1	
71.00	SPECIAL PURPOSE COST CENTERS		,,		0	,	7 1. 00
80.00							80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW				0		82.00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST CENTERS			0	0	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	30, 741	24, 001	27, 663	72, 003	24, 001	
	NONREI MBURSABLE COST CENTERS		,		. =, =, =		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	C			0	_	91. 00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0		0	0	92.00
94.00	09400 PATIENTS LAUNDRY			0	0	0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		ol o	ő	0	ő	95. 00
98.00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00		419, 907	284, 579	344, 458	921, 128	389, 530	102. 00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	13. 659510	11. 856964	12. 451939	12. 792911	16. 229740	103 00
103.00		40, 284	l .	1	69, 628		104. 00
	Part II)	12,20			21, 320		
105.00		1. 310432	1. 801550	1. 937498	0. 967015	0. 077288	105. 00
	1)	I	I	I	ľ	I	I

Heal th	Fi nan	cial Systems	RI DGEWOOD	CENT	ER		In Lie	u of Form CMS-:	2540-10
COST A	LLOCA	FION - STATISTICAL BASIS			Provi der		Period: From 01/01/2021	Worksheet B-1	
							Γο 12/31/2021	Date/Time Pre	pared:
		Cost Center Description	CENTRAL	PH	ARMACY	MEDI CAL	SOCIAL SERVICE	5/19/2022 1: 2 NURSI NG AND	4 pm
		oost conten bescription	SERVICES &		COSTED	RECORDS &	SOUTHE SERVICE	ALLI ED HEALTH	
			SUPPLY (COSTED	RE	QUI S.)	LI BRARY (GROSS	(TOTAL PATIENT	EDUCATION (ASSI GNED	
			REQUIS.)			CHARGES)	DAYS)	TI ME)	
			10.00	•	11. 00	12.00	13.00	14. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES				I	1		1.00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT							2.00
3.00	1	EMPLOYEE BENEFITS							3. 00
4.00		ADMINISTRATIVE & GENERAL							4.00
5. 00 6. 00	1	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE							5. 00 6. 00
7. 00	1	HOUSEKEEPI NG							7. 00
8.00	1	DI ETARY							8. 00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	28, 772						9. 00 10. 00
		PHARMACY	0		0				11.00
		MEDICAL RECORDS & LIBRARY	0		0	11, 557, 12			12. 00
	1	SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0		0		24, 001	0	13. 00 14. 00
		ACTIVITIES			0			0	15.00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS							
		SKILLED NURSING FACILITY	28, 772		0	1		0	
		NURSING FACILITY ICF/IID	0		0		0 0	0	31. 00 32. 00
		OTHER LONG TERM CARE	o		0	•		0	33. 00
		LARY SERVICE COST CENTERS					.1 _1	_	
	1	RADI OLOGY LABORATORY	0		0	17, 23, 15, 77		0	40. 00 41. 00
		INTRAVENOUS THERAPY	0		0	4, 10		0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	O		0	170		0	43.00
	1	PHYSI CAL THERAPY	0		0	423, 38		0	44. 00
		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0		0	399, 25: 199, 50		0	45. 00 46. 00
		ELECTROCARDI OLOGY	o o		0	1		0	47. 00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0	48. 00
	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0		0	110, 36		0	49. 00 50. 00
		SUPPORT SURFACES	o		0	618		0	51.00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	0		0		0	0	52.00
60. 00		TIENT SERVICE COST CENTERS	O			Ι ,	o lo	0	60.00
61. 00		RURAL HEALTH CLINIC	0		0			0	61.00
	06200	l .							62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0		0)	0	0	63. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	O		0) (ol lo	0	70.00
		AMBULANCE	o o		0	1		0	
	07200		0		0		0	0	
	07300	CMHC OTHER REIMBURSABLE COST	0		0			0	73. 00 74. 00
74.00		AL PURPOSE COST CENTERS	<u> </u>			1	<u> </u>	0	74.00
		MALPRACTICE PREMIUMS & PAID LOSSES							80.00
	1	INTEREST EXPENSE UTILIZATION REVIEW							81. 00 82. 00
83. 00		HOSPICE	o		0		ol ol	0	1
84.00		OTHER SPECIAL PURPOSE COST CENTERS	O		0)	o	0	84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	28, 772		0	11, 557, 12	4 24, 001	0	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O		0		o lo	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	O		0	1	o	0	91.00
	1	PHYSICIANS PRIVATE OFFICES	0		0			0	92.00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY	0		0			0	
95. 00		OTHER NONREIMBURSABLE COST CENTERS	o		0			0	
98.00		Cross Foot Adjustments							98.00
99. 00 102. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	126, 874		0	58, 940	182, 630	0	99. 00 102. 00
. 52. 00		Part I)	120,074		0	35, 74	132, 030		
103.00		Unit cost multiplier (Wkst. B, Part I)	4. 409634		0. 000000	i		0. 000000	
104. 00		Cost to be allocated (per Wkst. B, Part II)	40, 038		0	6, 83	3, 629	0	104. 00
105.00		Unit cost multiplier (Wkst. B, Part	1. 391561		0. 000000	0. 00059:	0. 151202	0. 000000	105. 00
	[11)	l l			I			

RI DGEWOOD CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2021 Date/Time Prepared: 5/19/2022 1:24 pm Provi der No.: 315158

				10 12/31/2021 Date/11me Pre	
			OTHER GENERAL		
			SERVI CE		
		Cost Center Description	ACTI VI TI ES		
			(TOTAL PATIENT		
			DAYS) 15. 00		
	GENER	AL SERVICE COST CENTERS	13.00		
1.00		CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300	EMPLOYEE BENEFITS			3. 00
4.00	1	ADMINISTRATIVE & GENERAL			4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	1	LAUNDRY & LINEN SERVICE			6. 00
7. 00 8. 00		HOUSEKEEPI NG DI ETARY			7. 00 8. 00
9. 00		NURSI NG ADMI NI STRATI ON			9. 00
10.00	1	CENTRAL SERVICES & SUPPLY			10.00
11.00	01100	PHARMACY			11. 00
12.00	1	MEDICAL RECORDS & LIBRARY			12. 00
13.00	1	SOCIAL SERVICE			13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	24 001		14.00
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	24, 001		15. 00
30. 00		SKILLED NURSING FACILITY	24, 001		30.00
31. 00		NURSING FACILITY	0		31.00
32.00	03200	ICF/IID	О		32. 00
33. 00		OTHER LONG TERM CARE	0		33. 00
40.00		LARY SERVICE COST CENTERS			40.00
40. 00 41. 00	1	RADI OLOGY LABORATORY	0		40.00
42. 00	1	INTRAVENOUS THERAPY	0		42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	Ö		43. 00
44.00	1	PHYSI CAL THERAPY	0		44. 00
45. 00	1	OCCUPATIONAL THERAPY	0		45. 00
46. 00 47. 00	1	SPEECH PATHOLOGY	0		46. 00
47.00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0		47. 00 48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0		49. 00
50. 00	1	DENTAL CARE - TITLE XIX ONLY	Ö		50.00
51.00	05100	SUPPORT SURFACES	O		51.00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	0		52. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	0		60.00
61.00	1	RURAL HEALTH CLINIC	0		61. 00
62. 00	06200				62. 00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0		63. 00
		REIMBURSABLE COST CENTERS			
70.00		HOME HEALTH AGENCY COST AMBULANCE	0		70.00
71.00	07100		0		71. 00 72. 00
	07300		0		73. 00
74. 00	1	OTHER REIMBURSABLE COST	Ö		74. 00
		AL PURPOSE COST CENTERS			
80.00		MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00 82. 00	1	INTEREST EXPENSE UTILIZATION REVIEW			81. 00 82. 00
83. 00		HOSPI CE	0		83. 00
84. 00		OTHER SPECIAL PURPOSE COST CENTERS	o		84. 00
89. 00		SUBTOTALS (sum of lines 1-84)	24, 001		89. 00
		MBURSABLE COST CENTERS			
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0		91. 00 92. 00
93. 00	1	NONPAID WORKERS	0		93. 00
94. 00		PATI ENTS LAUNDRY	Ö		94. 00
95.00		OTHER NONREIMBURSABLE COST CENTERS	O		95. 00
98. 00		Cross Foot Adjustments			98. 00
99.00		Negative Cost Centers	245 45/		99. 00
102.00	7	Cost to be allocated (per Wkst. B, Part I)	215, 456		102. 00
103.00	o	Unit cost multiplier (Wkst. B, Part I)	8. 976959		103. 00
104.00	1	Cost to be allocated (per Wkst. B,	22, 005		104. 00
		Part II)			
105.00)	Unit cost multiplier (Wkst. B, Part	0. 916837		105. 00
	1	11)	ı I		I

Health Financial Systems	RI DGEWOOD CENTER	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FO	OR ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315158 Pe	eriod: Worksheet C

From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/19/2022 1:24 pm Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 18, 438 17, 234 1.069862 40.00 41.00 04100 LABORATORY 6, 239 15, 776 0.395474 41.00 4, 104 42.00 04200 I NTRAVENOUS THERAPY 2, 470 0.601852 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 11, 416 176 64.863636 43.00 44. 00 04400 PHYSI CAL THERAPY 202, 548 423, 387 0.478399 44.00 04500 OCCUPATIONAL THERAPY 0. 417501 45.00 166, 688 399, 252 45.00 04600 SPEECH PATHOLOGY 0.502677 199, 506 46.00 100, 287 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 7, 708 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 49.00 127, 538 110, 360 1. 155654 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 51.00 05100 SUPPORT SURFACES 58, 441 618 94. 564725 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0.000000 60.00 06000 CLI NI C 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 63.00 63.00 0 0.000000 0 71. 00 | 07100 | AMBULANCE 0 0.000000 71.00

701, 773

1, 170, 413

100.00

100.00

Total

Health Financial Systems	RI DGEWOOD		N 045450		u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 01/01/2021	Worksheet D Part I	
				To 12/31/2021		pared:
					5/19/2022 1:2	4 pm
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Health Care Pr	rogram Charges	Health Care	Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1	Dont D (oal 1	
cost center bescription	to Charges	Pail A	Part b	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X COI . 2)	X COI. 3)	
	Col umn 3)					
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT					<u> </u>	
ANCILLARY SERVICE COST CENTERS						1
40. 00 04000 RADI OLOGY	1. 069862	5, 367		0 5, 742	0	40.00
41. 00 04100 LABORATORY	0. 395474	5, 529		0 2, 187	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 601852	547		0 329	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	64. 863636	0		0	0	43.00
44.00 O4400 PHYSI CAL THERAPY	0. 478399	110, 939		0 53, 073	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 417501			0 54, 308	0	
46.00 O4600 SPEECH PATHOLOGY	0. 502677			0 27, 216	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0	0	1 .0.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 155654			0 47, 620	0	1 . ,
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES	94. 564725			0	0	
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
60. 00 06000 CLI NI C	0. 000000	0		0	0	
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC	0.005	_		-	_	62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0	0	
71. 00 07100 AMBULANCE (2)	0. 000000			0 100 :==	0	
100.00 Total (Sum of lines 40 - 71)		347, 809	l	0 190, 475	0	100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	у.					

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

	51 1 1 0 1	D. DOEWOOD	OFNITED			6.5.	
	Financial Systems IONMENT OF ANCILLARY AND OUTPATIENT COSTS	RI DGEWOOD			Period: From 01/01/2021 To 12/31/2021		pared:
			Ti tl	e XVIII	Skilled Nursing Facility		
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1. 00 2. 00 3. 00	Drugs charged to patients - ratio of co Program vaccine charges (From your reco Program costs (Line 1 x line 2) (Title E, Part I, line 18)	ords, or the PS	&R)		ŕ	1. 155654 952 1, 100	1. 00 2. 00 3. 00
	Cost Center Description		Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Allied Healt	I I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	18, 438		0. 00000			1 .0.00
	04100 LABORATORY	6, 239		0. 00000	, ,		41. 00
	04200 I NTRAVENOUS THERAPY	2, 470	0	0.00000		0	
	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	11, 416	0	0. 00000 0. 00000		0 0	
	04500 OCCUPATIONAL THERAPY	202, 548 166, 688		0.00000			
	04600 SPEECH PATHOLOGY	100, 088		0.00000			
	04700 ELECTROCARDI OLOGY	100, 207	0	0. 00000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 708		0.00000		Ö	48. 00
	04900 DRUGS CHARGED TO PATIENTS	127, 538		0. 00000			
	05000 DENTAL CARE - TITLE XIX ONLY	0	Ö	0.00000		0	
	05100 SUPPORT SURFACES	58, 441	Ö	0.00000		Ō	
	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	Ō	0.00000		0	ł
100.00	Total (Sum of lines 40 - 52)	701, 773	0		190, 475	0	100. 00

Heal th	Financial Systems RIDGEWOOD CEN	TER	In Lie	u of Form CMS-2	2540-10
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315158	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Preps/19/2022 1:24	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
1.00	Inpatient days including private room days			24, 001	1. 00
2.00	Private room days			100	
3.00	Inpatient days including private room days applicable to the Pr			1, 692	3. 00
4.00	Medically necessary private room days applicable to the Program			0	4.00
5.00	Total general inpatient routine service cost			7, 159, 786	5. 00
6. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			10, 303, 329	6. 00
7. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 694900	
8.00	Enter private room charges from your records	vided by inite of		49, 800	8.00
9. 00	Average private room per diem charge (Private room charges line	8 divided by private	room days. line	498. 00	
	2)	3 p			
10.00	Enter semi-private room charges from your records			10, 253, 529	10. 00
11. 00	Average semi-private room per diem charge (Semi-private room c	harges line 10, divide	ed by	429. 00	11. 00
10.00	semi -private room days)	11 44			40.00
12.00	Average per diem private room charge differential (Line 9 minus			69.00	
13. 00 14. 00	Average per diem private room cost differential (Line 7 times I Private room cost differential adjustment (Line 2 times line 13			47. 95 4, 795	
15. 00	General inpatient routine service cost net of private room cost		minus line 14)	7, 154, 991	15.00
13.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 3	IIII IIus IIIIe 14)	7, 134, 771	13.00
16.00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		298. 11	16. 00
17.00	Program routine service cost (Line 3 times line 16)	,		504, 402	17. 00
18. 00	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		0	18. 00
19.00	Total program general inpatient routine service cost (Line 17			504, 402	19. 00
20. 00	Capital related cost allocated to inpatient routine service cos	ts (From Wkst. B, Par	t II column 18,	932, 694	20. 00
04 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			20.04	04 00
21. 00	Per diem capital related costs (Line 20 divided by line 1)			38. 86	
22.00	Program capital related cost (Line 3 times line 21)			65, 751	22. 00 23. 00
23. 00 24. 00	Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From prov	ider records)		438, 651 0	24.00
25. 00	Total program routine service costs for comparison to the cost		nus line 24)	438, 651	25.00
26. 00	Enter the per diem limitation (1)		1100 27)	430, 031	26.00
27. 00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27. 00
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the				28. 00
	(Transfer to Worksheet E, Part II, line 4) (See instructions)				
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX		
				1. 00	

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	24, 001	1. 00
2.00	Program inpatient days (see instructions)	1, 692	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. 070497	4.00
5. 00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	RI DGEWOOD CENT	ΓER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FO	OR TITLE XVIII	Provi der No.: 315158	From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Prepared: 5/19/2022 1:24 pm
		Ti +Lo VVIII	Skilled Nursing	DDC

				3/19/2022 1.2	4 pili
		Title XVIII	Skilled Nursing Facility	PPS	
		-		-	
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1. 00	Inpatient PPS amount (See Instructions)			1, 192, 753	
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	
3. 00	Subtotal (Sum of lines 1 and 2)			1, 192, 753	
4.00	Pri mary payor amounts			0	4. 00
5.00	Coinsurance			205, 765	
6. 00	Allowable bad debts (From your records)			102, 750	
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		102, 750	
8. 00	Adjusted reimbursable bad debts. (See instructions)			66, 788	
9. 00	Recovery of bad debts - for statistical records only			0	
10. 00	Utilization review			0	
11. 00	Subtotal (See instructions)			1, 053, 776	
12. 00	Interim payments (See instructions)			1, 031, 469	
13.00	Tentati ve adjustment			0	
14. 00	OTHER adjustment (See instructions)			0	
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			0	14. 99
15. 00	Balance due provider/program (see Instructions)			22, 307	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			1, 100	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			· ·	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			952	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			952	
22. 00	Pri mary payor amounts			0	
23. 00	Coi nsurance and deducti bl es			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			952	
26. 00	Interim payments (See instructions)			428	
27. 00	Tentati ve adj ustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	
29. 00	Balance due provider/program (see instructions)			524	
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section 115.2	0	30.00

Health Financial Systems	RI DGEWOOD CEN	ΓER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLE	EMENT TITLE V and TITLE XIX ONLY	Provi der No.: 315158	From 01/01/2021	Worksheet E Part II Date/Time Prepared: 5/19/2022 1:24 pm
		Title XIX	Skilled Nursing	PPS

		THE XIX	Facility	113	
			Ĺ		
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	
4.00	Inpatient routine services (see instructions)			0	
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			0	
7.00	Differential in charges between semiprivate accommodations and	ess than semiprivate a	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)			0	8. 00
9.00	Pri mary payor amounts			0	
10. 00	Total Reasonable Cost (Line 8 minus line 9)			0	10. 00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges				11. 00
12. 00	Outpati ent service charges			0	
13. 00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	ess than semiprivate a	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa			-	16. 00
17. 00	Amounts that would have been realized from patients liable for	oayment for services or	n a charge basis	0	17. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	
19. 00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20. 00	Cost of covered services (see Instructions)			0	
21. 00	Deducti bl es			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl cost limit	y collected based on co	orrection of	0	27. 00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in p	orogram	0	28. 00
	utilization	·	J I		
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting frif minus, enter amount in parentheses)	om disposition of depre	eciable assets (0	30. 00
31. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	Interim payments	27 dia 20)		0	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overnavments in narenth	1999) (999	0	33. 00
33.00	Instructions)	over payments in parenti	(366	U	33.00
	1		1	· ·	1

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315158 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/19/2022 1: 24 pm |

Title XVIII | Skilled Nursing | PPS

		11 (1	e XVIII S	Killed Nursing	PPS	
		Innation	t Part A	Facility	t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 018, 861		428	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, enter zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	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	06/03/2021	12, 608		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54	Cubatatal (Cum of Lines 2 01 2 40 minus aug of Lines 2 50		12 (00		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 -3.98)		12, 608		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 031, 469		428	4. 00
4.00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		1, 031, 407		420	4.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Describer to Describe		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
3. 77	- 5. 98)		O		Ĭ	5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		22, 307		524	6. 01
6.02	PROVI DER TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 053, 776		952	7. 00
			Contract	tor Name	Contractor	
					Number	
0.00			1.	00	2. 00	0.00
	Name of Contractor					8. 00

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

Health Financial Systems

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

Provi der No.: 315158 | Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/19/2022 1:24 pm

ıı y <i>)</i>					5/19/2022 1: 2	4 pm
		General Fund	Specific E Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets					-
00	CURRENT ASSETS Cash on hand and in banks	1, 700	O	0	0	1. (
00	Temporary investments	1, 700	0	0	0	
00	Notes receivable	Ö	O	0	0	
00	Accounts receivable	1, 092, 091	0	0	0	4. (
00	Other receivables	-2, 121	0	0	0	1
00	Less: allowances for uncollectible notes and accounts	-148, 697	0	0	0	6.
00	recei vabl e I nventory	43, 733	0	0	0	7.
00	Prepai d expenses	43, 733	0	0	0	
00	Other current assets	-3, 790	0	0	0	
0. 00	Due from other funds	0	0	0	0	10.
. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	982, 916	0	0	0	11.
	FI XED ASSETS	1	1			
2. 00	Land	54, 345	0	0	0	
3. 00 1. 00	Land improvements Less: Accumulated depreciation	-10, 431	0	0	0	
5. 00	Buildings	10, 431	0	0	0	
5. 00	Less Accumulated depreciation	o o	Ö	0	0	
7. 00	Leasehold improvements	428, 166	0	0	0	17.
3. 00	Less: Accumulated Amortization	-164, 988		0	0	
9. 00	Fi xed equipment	89, 743		0	0	
0.00	Less: Accumulated depreciation	-66, 452	0	0	0	
2. 00	Automobiles and trucks Less: Accumulated depreciation	0	0	0	0	
3. 00	Major movable equipment	415, 766	_	0	0	
1. 00	Less: Accumulated depreciation	-300, 328		0	0	
5. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	25.
6. 00	Mi nor equipment nondepreciable	0	0	0	0	1
7. 00	Other fixed assets	0	0	0	0	1
3. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	445, 821	0	0	0	28.
9. 00	OTHER ASSETS Investments	1 0	0	0	0	29.
). 00	Deposits on Leases	0	0	0	0	
. 00	Due from owners/officers	-8, 743, 990		0	0	
2. 00	Other assets	2, 794, 646	0	0	0	32.
3. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-5, 949, 344		0	0	
1. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	-4, 520, 607	0	0	0	34.
	Liabilities and Fund Balances CURRENT LIABILITIES					+
5. 00	Accounts payable	407, 569	0	0	0	35.
. 00	Salaries, wages, and fees payable	0	0	0	0	
7. 00	Payroll taxes payable	0	0	0	0	37.
3. 00	Notes & Loans payable (Short term)	0	0	0	0	
9. 00	Deferred income	0	0	0	0	1
0.00	Accelerated payments Due to other funds	81		0	0	40. 41.
2. 00	Other current liabilities	534, 278	0	0	0	
3. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	941, 928		0	0	
	LONG TERM LIABILITIES					
1. 00	Mortgage payable	4, 390, 446		0	0	
5. 00	Notes payable	0	0	0	0	1
00	Unsecured Loans	0	0	0	0	
7. 00 3. 00	Loans from owners: Other long term liabilities	0	0	0	0	1
9. 00	APIC DISTRIBUTIONS; R/E EARNINGS	-8, 835, 524		0	0	1
). 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-4, 445, 078		0	0	
. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-3, 503, 150		0	0	
	CAPI TAL ACCOUNTS					
. 00	General fund balance	-1, 017, 457				52.
3. 00	Specific purpose fund		0			53.
i. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 55.
5. 00	Governing body created - endowment fund balance			0		56.
7. 00	Plant fund balance - invested in plant			0	0	
3. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
						59.
9. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-1, 017, 457 -4, 520, 607		U	0	

In Lieu of Form CMS-2540-10 Health Financial Systems RI DGEWOOD CENTER Provider No.: 315158

STATEMENT OF CHANGES IN FUND BALANCES

12/31/2021

Peri od: Worksheet G-1 From 01/01/2021

Date/Time Prepared: 5/19/2022 1:24 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -1, 017, 457 2.00 Total (sum of line 1 and line 2) 3.00 -1, 017, 457 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 -1, 017, 457 Subtotal (line 3 plus line 10) 11.00 0 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 0000 14.00 0 14.00 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance -1, 017, 457 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 14.00 0 14.00 15.00 15.00 0 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00 sheet (Line 11 - line 18)

Health Financial Systems	RI DGEWOOD CENTER	In Lie	In Lieu of Form CMS-2540-10		
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315158	Peri od:	Worksheet G-2		

Hear th	Financial Systems Ribgewood Cen	IEK			In Lie	U OF FORM CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315158		riod: om 01/01/2021 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/19/2022 1:2	pared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY		10, 386, 7	11		10, 386, 711	1. 00
2.00	NURSING FACILITY			0		0	2. 00
3.00	ICF/IID			0		0	3. 00
4.00	OTHER LONG TERM CARE			0		0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		10, 386, 7	11		10, 386, 711	5. 00
	All Other Care Services						
6.00	ANCI LLARY SERVI CES		1, 182, 20	62	0	1, 182, 262	6. 00
7.00	CLINIC				0	0	7. 00
8.00	HOME HEALTH AGENCY COST				0	0	8. 00
9.00	AMBULANCE				0	0	9. 00
10.00	RURAL HEALTH CLINIC				0	0	10. 00
10. 10	FQHC				0	0	10. 10
11.00	CMHC				0	0	11. 00
11. 10	CORF				0	0	11. 10
12.00	HOSPI CE			0	0	0	12. 00
13.00	OTHER (SPECIFY)			0	0	0	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 Worksheet G-3, Line 1)	to	11, 568, 9	73	0	11, 568, 973	14. 00
	Cost Center Description						
	oost oonton beschiptron			H	1. 00	2. 00	
	PART II - OPERATING EXPENSES				1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			Т		8, 571, 487	1.00
2. 00	Add (Specify)				0	0, 0, 1, 10,	2. 00
3.00	(Specify)				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)				O	0	
9. 00	Deduct (Specify)				0	0	9. 00
10. 00	Deduct (Specify)				0		10. 00
11. 00					0		11. 00
12. 00					0		12.00
13. 00					0		13. 00
14. 00	Total Deductions (Sum of lines 9 - 13)				U	0	14. 00
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)					8, 571, 487	
13.00	Trotal operating expenses (Sum of Times Fand 6, minus Time 14)			- 1		0, 3/1, 48/	13.00

Health Financial Systems	RI DGEWOOD CENT	TER	In Lie	u of Form CMS-2	540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPEN	SES	Provi der No.: 315158	Peri od: From 01/01/2021	Worksheet G-3	
			To 12/31/2021	Date/Time Prep 5/19/2022 1:24	
·					
				1. 00	
1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			11, 568, 973	1. 00	
2.00 Less: contractual allowances and discounts on patients accounts				4, 035, 761	2.00
3.00 Net patient revenues (Line 1 minus line 2)				7, 533, 212	3.00

	To 12/31/2021	Date/Time Prep 5/19/2022 1:24	
		37 177 2022 1. 2	трш
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	11, 568, 973	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	4, 035, 761	2.00
3.00	Net patient revenues (Line 1 minus line 2)	7, 533, 212	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	8, 571, 487	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1, 038, 275	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase 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 supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21. 00	Rental of vending machines	0	21. 00
22. 00	Rental of skilled nursing space	0	22. 00
23. 00	Governmental appropriations	0	23.00
24. 00	MISC INCOME	20, 818	
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)	20, 818	
26. 00	Total (Line 5 plus line 25)	-1, 017, 457	
27. 00	Other expenses (specify)	0	27. 00
28. 00		0	28. 00
29. 00		0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	-1, 017, 457	31.00