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).

OMB NO. 0938-0463 Expires: 12/31/2021

			EMP11 001 127 017 2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315176	From 01/01/2021	Worksheet S Parts I, II & III Date/Time Prepared:

					4/20/2022 9:	59 am	
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically prepared cost re	oort		Date: 4/20/202	22 Time:	9:59 am	
use only	2. [] Manually prepared cost report						
	3. [0] If this is an amended report en	ter the numbe	of times the provider	resubmitted this	s cost repor	t	
	3.01 [] No Medicare Utilization. Enter '						
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 I	ne 4, column 1 is "4":	 Enter number of	times reope	ned	
	(5) Amended	11.Contracto	r Vendor Code	4	•		
	5. Date Received:		care Utilization. Ente no utilization.	r "F" for full, "	L" for low,	or "N"	

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEDFORD NRSG& CONVA. CENTER (315176) 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	Sand	dra Lowden	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	Sandra Lowden			2
3	Signatory Title	ADMI NI STRATOR			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	-35, 225	212	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-35, 225	212	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Heal th	Financial Systems	MEDFORD NI	RSG& CONVA	A. CENTER		ı	n Lieu	ı of Form	CMS-2	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA			Provi der No	o.: 315176	Period: From 01/01	/2021	Workshee Part I	et S-2	
00 22						To 12/31.		Date/Tim 4/20/202		
	1.00	_	. 00	ddmann	3. 00					
1. 00	Skilled Nursing Facility and Skilled Nursing Street: 185 TUCKERTON RD	PO Box:	Complex A	aaress:						1. 00
2.00	City: MEDFORD	State: NJ		Zi p Code: 0						2. 00
3. 00 3. 01	County: BURLI NGTON	CBSA Code		Urban/Rura	I: U					3. 00 3. 01
3.01		CBSA COUE		nent Name	Provi der	Date	Payme	ent Syster	m (P,	3.01
					CCN	Certi fied		0, or N)		
				1. 00	2.00	3. 00	4. 00		XI X 6. 00	
	SNF and SNF-Based Component Identification:				2.00				0.00	
4. 00	SNF		MEDFORD NE CENTER	RSG& CONVA.	315176	07/01/1980	N	P	N	4. 00
5.00	Nursing Facility		CENTER							5. 00
6.00	ICF/IID									6. 00
7. 00 8. 00	SNF-Based HHA SNF-Based RHC									7. 00 8. 00
9. 00	SNF-Based FQHC									9. 00
10.00	SNF-Based CMHC SNF-Based OLTC									10.00
11. 00 12. 00										11. 00 12. 00
13. 00	SNF-Based CORF						<u> </u>			13. 00
						1.00		To: 2. 00		
14. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/2		14. 00
15. 00	Type of Control (See Instructions)						4	\/ /N		15. 00
								Y/N 1.00		
	Type of Freestanding Skilled Nursing Facilit									
16. 00	Is this a distinct part skilled nursing faci section 483.5?	lity that	meets the	requi rement	s set forth	in 42 CFR		Υ		16. 00
17. 00	Is this a composite distinct part skilled nu	rsing faci	lity that	meets the r	equi rements	set forth	in	N		17. 00
10 00	42 CFR section 483.5?	that rocul	tod from	transacti ons	with rolat	ad		Υ		18. 00
16.00	Are there any costs included in Worksheet A organizations as defined in CMS Pub. 15-1, c							ĭ		16.00
	Miscellaneous Cost Reporting Information									
	If this is a low Medicare utilization cost rulf line 19 is yes, does this cost report mee						·e	N N		19. 00 19. 01
.,	utilization cost report, indicate with a "Y"	, for yes,	or "N" fo	or no.	Ü					. ,
20 00	Depreciation - Enter the amount of depreciat Straight Line	ion report	ed in thi	s SNF for th	ne method ir	ndi cated on	Li nes		50 640	20.00
	Declining Balance								0	
	Sum of the Year's Digits							_	0	22.00
	Sum of line 20 through 22 If depreciation is funded, enter the balance	e as of th	e end of	the period				5	59, 649 0	23.00
25. 00	Were there any disposal of capital assets du	ring the c	ost repor	ting period?				N		25. 00
26. 00	Was accelerated depreciation claimed on any	assets in	the curre	nt or any pr	ior cost re	porting per	i od?	N		26. 00
27. 00	(Y/N) Did you cease to participate in the Medicare	program a	t end of	the period t	o which thi	s cost repo	ort	N		27. 00
20.00	applies? (Y/N)			-£ -!!!-!				NI.		20.00
28. 00	Was there a substantial decrease in health in reports? (Y/N)	nsurance p	roportion	or allowabl	e cost from	prior cost		N		28. 00
								A Part B (
	If this facility contains a public or non-pu	ıblic provi	der that	qualifies fo	or an exemnt	ion from th	1.00 he appl		3.00	
	of the lower of the costs or charges enter "									
29. 00	exemption. Skilled Nursing Facility						l N	l N l		29. 00
	Nursing Facility						I IN	"	N	30.00
31.00	ICF/IID							.		31.00
32. 00 33. 00	SNF-Based HHA SNF-Based RHC						N	N N		32. 00 33. 00
34.00	SNF-Based FQHC									34.00
	SNF-Based CMHC SNF-Based OLTC							N		35. 00 36. 00
30.00	DISCU 0210					Y/N				33.00
					1	1. 00		2.00)	07.05
07.55		state tha		es the provi	der as a SN	F Y				37.00
37. 00	Is the skilled nursing facility located in a regardless of the level of care given for Ti	tles V & Y	IX patien	ts? (Y/N)			1		- 1	07.00
38. 00	regardless of the level of care given for Ti Are you legally-required to carry malpractic	e insuranc	e? (Y/N)			N				38. 00
	regardless of the level of care given for Ti Are you legally-required to carry malpractic Is the malpractice a "claims-made" or "occur	e insuranc rence" pol	e? (Y/N) icy? If tl			N 1				
38. 00	regardless of the level of care given for Ti Are you legally-required to carry malpractic	e insuranc rence" pol	e? (Y/N) icy? If tl		Premi ums	1	sses S	Gelf Insu	rance	38. 00
38. 00 39. 00	regardless of the level of care given for Ti Are you legally-required to carry malpractic Is the malpractice a "claims-made" or "occur	e insuranc rence" pol	e? (Y/N) icy? If tl			1		Self Insu 3.00 0		38. 00

alth Financial Systems MEDFORD NRSG& CONVA. CENTER In Li					2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315176	Peri od:	Worksheet S-2	
COMPLEX INDENTIFICATION DATA			From 01/01/2021	Part I	
			To 12/31/2021	Date/Time Pre	
				4/20/2022 9:5	9 am
				Y/N	
				1. 00	
42.00 Are malpractice premiums and paid loss	es reported in other than	the Administrative a	nd General cost	N	42. 00
center? Enter Y or N. If yes, check bo	x, and submit supporting s	schedule listing cost	centers and		
amounts.		-			
43.00 Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		N	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		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 name	e and address of the	home office on the	lines	
below.					
45. 00 Name:	Contractor's Name:	Contra	ctor's Number:		45. 00
46.00 Street:	PO Box:				46. 00
47. 00 Ci ty:	State:	Zi p Co			47. 00

Heal th	Financial Systems	MEDFORD NRSG& CONVA. (CENTER		In Lie	eu of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Pr	rovi der	No.: 315176	Peri od: From 01/01/2021 To 12/31/2021		epared:
					Y/N	4/20/2022 9:5 Date	9 am
	Constant to the first to the state of the st		"\/" <i>E</i> -	V !! N!!!	1. 00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy)	ses enter in column i,	Y TO	r yes or N	TOT NO. FOR ALL	the date	
	Completed by All Skilled Nursing Facilites						
1. 00	Provider Organization and Operation Has the provider changed ownership immediate	ly prior to the beginn	ning of	the cost	N		1.00
	reporting period? If column 1 is "Y", enter	the date of the change	in col	umn 2. (see			
	instructions)	-		Y/N	Date	V/I	
2.00	The the consider to a section to the	the Medicere December	1.6	1.00	2. 00	3.00	2.00
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date			N			2. 00
2 00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac	tions including manage	.cmcn+	Y			3. 00
3. 00	contracts, with individuals or entities (e.g.			ď			3.00
	or medical supply companies) that are related						
	officers, medical staff, management personne of directors through ownership, control, or						
	relationships? (see instructions)			Y/N	Type	Date	
				1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepare	ared by a Cortified Du	ıblic	Υ	C	I	4. 00
4.00	Accountant? (Y/N) Column 2: If yes, enter "A'			'	C		4.00
	Compiled, or "R" for Reviewed. Submit compleavailable in column 3. (see instructions) If						
5.00	Are the cost report total expenses and total			N			5. 00
	those on the filed financial statements? If reconciliation.	column 1 is "Y", submi	t				
	reconcilitation.				Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
6.00	Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2:	Is the	provider the	N	N	6. 00
7. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program:	s? (V/N) see instructi	ons		N		7. 00
8.00	Were approvals and/or renewals obtained duri	ng the cost reporting		for Nursing	N		8. 00
	School and/or Allied Health Program? (Y/N) se	ee instructions.				Y/N	
						1. 00	
9. 00	Bad Debts Is the provider seeking reimbursement for bar	d debts? (Y/N) see ins	structio	ns		Y	9.00
10. 00	If line 9 is "Y", did the provider's bad deb				st reporting	N	10. 00
11. 00	period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	d/or coinsurance waive	ed? If "	Y". see instr	ructions.	N	11. 00
	Bed Complement						
12. 00	Have total beds available changed from prior	cost reporting period	1? If "Y		uctions. art A	N Part B	12. 00
		Description		Y/N	Date	Y/N	
	PS&R Data	0		1. 00	2. 00	3. 00	
13. 00	Was the cost report prepared using the PS&R			Y	03/22/2022	Y	13. 00
	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						
14. 00	4. (see Instructions.) Was the cost report prepared using the PS&R			N		N	14. 00
	for total and the provider's records for						
	allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used						
	to prepare this cost report in columns 2 and						
15. 00	4. If line 13 or 14 is "Y", were adjustments			N		N	15. 00
	made to PS&R data for additional claims that						
	have been billed but are not included on the PS&R used to file this cost report? If "Y",						
1/ 00	see Instructions.			N		N	14 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for			N		N	16. 00
	corrections of other PS&R Report						
17. 00	information? If yes, see instructions. If line 13 or 14 is "Y", then were			N		N	17. 00
	adjustments made to PS&R data for Other? Describe the other adjustments:						
18. 00	Was the cost report prepared only using the			N		N	18. 00
	provider's records? If "Y" see Instructions.				1	I	I

Heal th	Financial Systems	MEDFORD NRSG& CO	ONVA. CENTER		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 4/20/2022 9:5	pared:
			1.	00	2.	00	-
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the titl held by the cost report preparer in columns respectively.		I TTY		BLI SSI T		19. 00
20. 00	Enter the employer/company name of the cost preparer.	report HI	IEALTH CARE RE	SOURCES			20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respecti		09-987-1440		KI TTY. BLI SSI T@I	HCRNJ. NET	21. 00

Health Financial Systems MEDFORD NRSG& C
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE MEDFORD NRSG& CONVA. CENTER Provi der No.: 315176

| Peri od: | Worksheet S-2 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: COMPLEX REIMBURSEMENT QUESTIONNAIRE

				То	12/31/2021	Date/Time Pre 4/20/2022 9:5	
		Part B			.,	., _,, _,,	
		Date					
		4.00					
	PS&R Data						
13.00	Was the cost report prepared using the PS&R	03/22/2022					13. 00
	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						14. 00
14.00	for total and the provider's records for						14.00
	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						15. 00
	made to PS&R data for additional claims that have been billed but are not included on the						
	PS&R used to file this cost report? If "Y",						
	see Instructions.						
16.00							16. 00
	adjustments made to PS&R data for						
	corrections of other PS&R Report						
	information? If yes, see instructions.						
17. 00	If line 13 or 14 is "Y", then were						17. 00
	adjustments made to PS&R data for Other? Describe the other adjustments:						
18 00	Was the cost report prepared only using the						18. 00
10.00	provider's records? If "Y" see Instructions.						10.00
			3. 00				
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title		PREPARER				19. 00
	held by the cost report preparer in columns 1 respectively.	i, 2, and 3,					
20. 00	Enter the employer/company name of the cost r	renort					20. 00
20.00	preparer.	opo. t					20.00
21. 00	Enter the telephone number and email address	of the cost					21. 00
	report preparer in columns 1 and 2, respective						

In Lieu of Form CMS-2540-10 MEDFORD NRSG& CONVA. CENTER

Health Financial Systems MEDFORD NRSG& CONTROL NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Provi der No.: 315176

					0 12/31/2021	4/20/2022 9: 59	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	180	65, 700			25, 856	1.00
2.00	NURSING FACILITY	0	0			0	2.00
3.00	ICF/IID	0	0		0	0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST	0	_	0	0	0	4. 00 5. 00
6.00	Other Long Term Care SNF-Based CMHC		U				6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	180	65, 700			25, 856	8. 00
	, , , , , , , , , , , , , , , , , , , ,	Inpatient D			Di scharges	, , , , , ,	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CKILLED MUDCING FACILLEY	6.00	7.00	8. 00	9. 00 121	10.00	1. 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	11, 126 0	41, 503 0			0	2. 00
3.00	ICF/IID		0	U			3. 00
4.00	HOME HEALTH AGENCY COST	0	0				4. 00
5. 00	Other Long Term Care	o	Ö				5. 00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	11, 126				212	8. 00
		Di sch	arges	Aver			
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	285	618			121. 96	1.00
2.00	NURSING FACILITY	0	0			0.00	2.00
3. 00 4. 00	HOME HEALTH AGENCY COST		U			0. 00	3. 00 4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC						6. 00
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8.00	Total (Sum of lines 1-7)	285	618	0.00	37. 36	121. 96	8.00
		Average Length		Admi s	si ons		
	Companent	of Stay	T: +1 o V	Title XVIII	Ti +I o VI V	Othon	
	Component	Total 16.00	Title V 17.00	18. 00	Title XIX 19.00	0ther 20.00	
1.00	SKILLED NURSING FACILITY	67. 16				20.00	1. 00
2.00	NURSING FACILITY	0.00		120	0	0	2. 00
3.00	ICF/IID	0. 00			0	ol ol	3. 00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7. 00	HOSPICE	0.00		0		0	7. 00
8. 00	Total (Sum of lines 1-7)	67.16 Admissions	Full Time	128 Equi val ent	213	285	8. 00
		_					
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I	Workers 23.00			
1.00	SKILLED NURSING FACILITY	21.00	22. 00 109. 90				1. 00
2.00	NURSING FACILITY	020					2. 00
3.00	ICF/IID	l o					3. 00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5.00	Other Long Term Care	0					5. 00
6.00	SNF-Based CMHC		0.00				6.00
7.00	HOSPI CE	0					7. 00
8. 00	Total (Sum of lines 1-7)	626	109. 90	0.00			8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION MEDFORD NRSG& CONVA. CENTER

					rom 01/01/2021 o 12/31/2021	Part II Date/Time Pre	pared:
						4/20/2022 9:5	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
4 00	SALARI ES (C.)	F 404 00F		F 404 00F	000 007 00	00.74	4 00
1.00	Total salaries (See Instructions)	5, 431, 895		5, 431, 895			1.00
2.00	Physician salaries-Part A	0	0		0. 00		2. 00
3. 00	Physician salaries-Part B	0	0		0.00		
4.00	Home office personnel	0	0	(0.00		
5.00	Sum of lines 2 through 4	0	0	(0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	5, 431, 895	0	5, 431, 895			6. 00
7.00	Other Long Term Care	0	0	(0.00		7. 00
8.00	HOME HEALTH AGENCY COST	0	0	(0.00		
9.00	CMHC	0	0	(0.00	0.00	9. 00
10.00	HOSPI CE	0	0	(0.00		10.00
11. 00	Other excluded areas	0	0	(0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	C	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	5, 431, 895	0	5, 431, 895	228, 807. 00	23. 74	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	794, 427	0	794, 427	16, 061. 00	49. 46	14.00
15.00	Contract Labor: Physician services-Part A	0	0	(0.00	0.00	15. 00
16. 00	Home office salaries & wage related costs	0	C	C	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	992, 131	C	992, 131			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	C			18. 00
19.00	Wage related costs (excluded units)	0	0	()		19. 00
20.00	Physician Part A - WRC	0	0	()		20.00
21.00	Physician Part B - WRC	0	0	()		21. 00
22.00	Total Adjusted Wage Related cost (see	992, 131	0	992, 131			22. 00
	instructions)						
		•	•	•	•		

Health Financial Systems
SNF WAGE INDEX INFORMATION MEDFORD NRSG& CONVA. CENTER

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: Provi der No.: 315176

				'	0 12/31/2021	4/20/2022 9:59	
	·	Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	C) C	0.00	0.00	1. 00
2.00	Administrative & General	475, 340	C	475, 340	15, 698. 00	30. 28	2. 00
3.00	Plant Operation, Maintenance & Repairs	137, 026	[C	137, 026	6, 726. 00	20. 37	3. 00
4.00	Laundry & Linen Service	102, 910	C	102, 910	7, 186. 00	14. 32	4. 00
5.00	Housekeepi ng	354, 345	C	354, 345	24, 591. 00	14. 41	5. 00
6.00	Di etary	563, 000	C	563, 000	31, 505. 00	17. 87	6. 00
7.00	Nursing Administration	587, 679	C	587, 679	19, 980. 00	29. 41	7. 00
8.00	Central Services and Supply	15, 779	C	15, 779	982.00	16. 07	8. 00
9.00	Pharmacy	0	C) c	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	C	0	0.00	0.00	10.00
11. 00	Soci al Servi ce	103, 297	C	103, 297	3, 333. 00	30. 99	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	159, 686	C	159, 686	9, 369. 00	17. 04	13.00
14. 00	Total (sum lines 1 thru 13)	2, 499, 062	c	2, 499, 062	119, 370. 00	20. 94	14. 00

Health Financial Systems	MEDFORD NRSG& CONVA. CENTER	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No. : 315176	Peri od: Worksheet S-3 From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared:

	To 12/31/2021		
		Amount	
		Reported	
	DATE IV. WAS DELATED AGOTO	1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST	_	
1.00	401K Empl oyer Contri butions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	302, 746	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	17, 081	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	2, 148	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	473	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	Workers' Compensation Insurance	120, 689	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	425, 527	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	123, 467	20. 00
	OTHER		
21.00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 - 23)	992, 131	
2 20		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
		1	

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provi der No.: 315176 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part V | To 12/21/2021 | Part V |

0.00

0.00 26.00

12/31/2021 Date/Time Prepared: 4/20/2022 9:59 am Occupational Category Amount Fri nge Adj usted Pai d Hours Average Hourly Benefits Sal ari es (col Related to Reported Wage (col. 3 col . 4) 1 + col. 2Salary in col 5. 00 3.00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 670, 137 122, 400 792, 537 17, 665, 00 44.86 1.00 169, 945 Licensed Practical Nurses (LPNs) 930, 445 1, 100, 390 27, 229, 00 40.41 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 919, 758 167, 993 1, 087, 751 50, 594. 00 21.50 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 2, 520, 340 460, 338 2, 980, 678 95, 488. 00 31.22 4.00 5.00 49, 016 8,003.00 5.00 Physical Therapists 268 359 317, 375 39 66 Physical Therapy Assistants 21.89 6.00 11, 105 2,028 13, 133 600.00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 8.00 119, 937 21, 906 141.843 2.036.00 69.67 8.00 21.88 9.00 38, 443 7, 022 45, 465 2,078.00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 11.00 Speech Therapists 53,844 9,835 63, 679 1, 232. 00 51.69 11.00 12.00 Respiratory Therapists 0.00 12 00 0 0 00 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 278 530 278, 530 4, 550. 00 61 22 14 00 15.00 Licensed Practical Nurses (LPNs) 464, 507 464, 507 9, 484. 00 48.98 15.00 Certified Nursing Assistant/Nursing 48, 255 48, 255 1, 971. 00 24. 48 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 791, 292 791, 292 16, 005. 00 49.44 17.00 18.00 Physical Therapists 0.00 0.00 18.00 0 0 19.00 Physical Therapy Assistants 0 0 0.00 0.00 19.00 Physical Therapy Aides 0 20.00 0.00 0.00 20.00 Occupational Therapists 0.00 21.00 0 0 0.00 21.00 Occupational Therapy Assistants 22.00 0 0 0.00 0.00 22.00 Occupational Therapy Aides 0 0 0.00 0.00 23.00 23.00 24.00 Speech Therapists 0 0.00 0.00 24.00 Respiratory Therapists 55.00 25.00 25.00 3, 135 3, 135 57.00

26.00 Other Medical Staff

From 01/01/2021 12/31/2021 Date/Time Prepared: 4/20/2022 9:59 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38, 00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB2 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75. 00 PA₂

Health Financial Systems	MEDFORD NRSG& CONVA	A. 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 Pr 4/20/2022 9:		
				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 Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101.00 Staffing						101. 00	
102.00 Recruitment						102. 00	
103.00 Retention of employees						103. 00	
104. 00 Trai ni ng						104. 00	
105. 00 OTHER (SPECIFY)						105. 00	
106.00 Total SNF revenue (Worksheet G-2, Part I, I	ine i, column 3)		1			106. 00	

Health Financial S	ystems	MEDFORD NRSG& CON\	/A. CENTER		In Lie	u of Form CMS-2	2540-10
	AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		'eri od:	Worksheet A	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre	pared·
					12,01,2021	4/20/2022 9:5	9 am
Cost (Center Description	Sal ari es	0ther		Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons	Tri al Bal ance	
					I ncrease/Decre		
					ase (Fr Wkst	col. 4)	
		1.00	2.00	2.00	A-6)	F 00	
CENEDAL CED	U.C. COCT CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
	VI CE COST CENTERS		1 22/ 1/1	1 22/ 1/1	0	1 227 141	1 00
	EL COSTS - BLDGS & FLXTURES		1, 336, 141			1, 336, 141	1.00
	/EE BENEFITS	0	993, 671		l l	993, 671	3.00
	STRATIVE & GENERAL	475, 340	1, 798, 047		l l	2, 273, 387	4. 00
	OPERATION, MAINT. & REPAIRS	137, 026	453, 347			590, 373	5. 00
1 1	RY & LINEN SERVICE	102, 910	22, 817			125, 727	6.00
		354, 345	33, 396			387, 741	7. 00
8. 00 00800 DI ETAF		563, 000	477, 595			1, 040, 595	8. 00
	NG ADMINISTRATION	587, 679	0	587, 679		587, 679	9. 00
	AL SERVICES & SUPPLY	15, 779	0	15, 779	0	15, 779	10.00
	AL RECORDS & LIBRARY	0	0	100 00	0	0	12.00
13. 00 01300 SOCIAL		103, 297	0	103, 297		103, 297	13.00
15. 00 01500 RECREA		159, 686	12, 932	172, 618	0	172, 618	15. 00
	OUTINE SERVICE COST CENTERS	0 444 045	1 0 10 000	0 400 040	ا	0 100 010	00.00
	ED NURSING FACILITY	2, 441, 245	1, 048, 803	3, 490, 048	0	3, 490, 048	30.00
31. 00 03100 NURSI N		0	0		0	0	31.00
32. 00 03200 CF/II		0	0		0	0	32.00
	LONG TERM CARE	0	0	C	0	0	33. 00
	ERVICE COST CENTERS		15 204	15 204		15 204	40.00
40. 00 04000 RADI OL		0	15, 384			15, 384	40.00
41. 00 04100 LABORA		0	21, 757			21, 757	41.00
	/ENOUS THERAPY	0	10, 273			10, 273	42.00
	N (INHALATION) THERAPY	0	10, 686			10, 686	43.00
44. 00 04400 PHYSI (279, 364	0	279, 364		279, 364	44.00
	ATI ONAL THERAPY	158, 380	0	158, 380		158, 380	45. 00
46. 00 04600 SPEECH		53, 844	0	53, 844		53, 844	46.00
	ROCARDI OLOGY		4 400	4 400		0	47. 00
	AL SUPPLIES CHARGED TO PATIENTS		4, 692			4, 692	48. 00
	CARGED TO PATIENTS	0	259, 071			259, 071	49.00
	CARE - TITLE XIX ONLY	0	0	C	-	0	50.00
51. 00 05100 SUPPOR	SERVICE COST CENTERS	0	0	<u> </u>	ıl U	U	51. 00
60. 00 06000 CLINIC		0	0		ol ol	0	60.00
	HEALTH CLINIC		0			0	61.00
62. 00 06200 FQHC	HEALTH CLINIC		U		'	Ü	62.00
	URSABLE COST CENTERS						02.00
	HEALTH AGENCY COST	O	0		ol	0	70. 00
71. 00 07100 AMBULA			18, 866				70.00
73. 00 07300 CMHC	ANCL		18, 800			18, 800	73.00
	POSE COST CENTERS	<u> </u>			<u>'</u>		73.00
	ACTICE PREMIUMS & PAID LOSSES		0	C	ol	0	80. 00
81. 00 08100 NTERE			0			0	81.00
	ZATION REVIEW - SNF		0			0	82. 00
83. 00 08300 H0SPI (0			0	83. 00
1 1	TALS (sum of lines 1-84)	5, 431, 895	6, 517, 478	11, 949, 373		11, 949, 373	89. 00
	ABLE COST CENTERS	3, 431, 073	0, 317, 470	11, 747, 373	<u> </u>	11, 747, 373	0 7. 00
	FLOWER, COFFEE SHOPS & CANTEEN		2, 369	2, 369	ار ا	2, 369	90.00
	R AND BEAUTY SHOP		7, 513			7, 513	
	CLANS PRIVATE OFFICES		7,513	7, 513		7, 513	92.00
93. 00 09300 NONPAI			0]		0	93.00
94. 00 09400 PATIEN			0]		0	94. 00
100. 00 TOTAL	NIO LAUNDINI	5, 431, 895	6, 527, 360	11, 959, 255	0	11, 959, 255	
100.00 101AL		3, 431, 675	0, 327, 300	11, 757, 255	ı 이	11, 737, 233	1100.00

MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 MEDFORD NR

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 | Peri od: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provi der No.: 315176

	4/20/2022 9:59 am
Cost Center Description Adjustments to Net Expenses	4/20/2022 7. 37 (311)
Expenses (Fr For Allocation	
₩kst A-8) (col. 5 +-	
col. 6)	
6.00 7.00	
GENERAL SERVI CE COST CENTERS	1.00
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES -12,688 1,323,453 3.00 00300 EMPLOYEE BENEFITS 0 993,671	1.00
4. 00 00400 ADMI NI STRATI VE & GENERAL -910, 446 1, 362, 941	4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 1,302,741	5. 00
6.00 00600 LAUNDRY & LI NEN SERVI CE 0 125, 727	6. 00
7. 00 00700 HOUSEKEEPI NG 0 387, 741	7. 00
8.00 00800 DI ETARY -10 1,040,585	8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON 0 587, 679	9.00
10. 00 01000 CENTRAL SERVI CES & SUPPLY 0 15, 779	10. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 0 0 0	12. 00
13. 00 01300 SOCI AL SERVI CE 0 103, 297	13. 00
15. 00 01500 RECREATION 0 172, 618	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 SKI LLED NURSI NG FACI LI TY 3, 744 3, 493, 792	30.00
31. 00 03100 NURSI NG FACI LI TY 0 0	31.00
32. 00 03200 I CF/I I D	32.00
33. 00 03300 OTHER LONG TERM CARE 0 0	33. 00
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI 0LOGY 0 15, 384	40.00
40. 00 04000 RADI 0LOGY	40.00
42. 00 04200 I NTRAVENOUS THERAPY 0 10, 273	42.00
43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 0 10, 686	43.00
44. 00 04400 PHYSI CAL THERAPY 0 279, 364	44.00
45. 00 04500 0CCUPATI ONAL THERAPY 0 158, 380	45. 00
46. 00 04600 SPEECH PATHOLOGY 0 53, 844	46. 00
47. 00 04700 ELECTROCARDI OLOGY 0 0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 4,692	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 259, 071	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0	50.00
51. 00 05100 SUPPORT SURFACES 0 0	51. 00
OUTPATIENT SERVICE COST CENTERS	
60. 00 06000 CLI NI C 0 0	60. 00
61.00 06100 RURAL HEALTH CLINIC 0 0	61. 00
62. 00 06200 FQHC	62. 00
OTHER REIMBURSABLE COST CENTERS	70.00
70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 71. 00 07100 AMBULANCE 0 18, 866	70.00
71. 00 07100 AMBULANCE 0 18, 866 73. 00 07300 CMHC 0 0	71.00
SPECIAL PURPOSE COST CENTERS	73.00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 0 0	80.00
81. 00 08100 INTEREST EXPENSE 0 0	81. 00
82. 00 08200 UTI LI ZATI ON REVIEW - SNF 0 0	82.00
83. 00 08300 HOSPI CE 0 0	83. 00
89.00 SUBTOTALS (sum of lines 1-84) -919,400 11,029,973	89. 00
NONREI MBURSABLE COST CENTERS	
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 2, 369	90.00
91. 00 09100 BARBER AND BEAUTY SHOP 0 7, 513	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0	92. 00
93. 00 09300 NONPALD WORKERS 0 0	93. 00
94. 00 09400 PATI ENTS LAUNDRY 0 0	94.00
100. 00 TOTAL -919, 400 11, 039, 855	100.00

Health Financial Systems	MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-				u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315176	Peri od:	Worksheet A-6	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre	
					4/20/2022 9:5	9 am
	Increases					
	Cost Center	•	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
TOTALS						
100. 00	Total Reclassificati	ons (Sum		0	0	100.00
	of columns 4 and 5 must					
	equal sum of columns	s 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	MEDFORD NRSG& CONVA	CENTER		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6)
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre	epared:
					4/20/2022 9:5	9 am
	Decreases					
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-2540-10

Provider No.: 315176 | Period: | Worksheet A-7 | From 01/01/2021 | To 12/31/2021 | Date/Time Preparent

					То	12/31/2021	Date/Time Prep 4/20/2022 9:59	oared: 9 am
				Acqui si ti ons	S			
	Description	Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
	T	1.00	2. 00	3. 00		4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					al		
1.00	Land	118, 000	0		0	0	0	1. 00
2.00	Land Improvements	0	0		0	0	0	2. 00
3.00	Buildings and Fixtures	5, 054, 443	0		0	0	0	3. 00
4.00	Building Improvements	0	0		0	0	0	4. 00
5.00	Fi xed Equipment	0	0		0	0	0	5. 00
6.00	Movable Equipment	3, 132, 139	0		0	0	0	6. 00
7. 00	Subtotal (sum of lines 1-6)	8, 304, 582	0		0	0	0	7. 00
8.00	Reconciling Items	0	0		0	0	0	8.00
9. 00	Total (line 7 minus line 8)	8, 304, 582	0		0	0	0	9. 00
	Description	Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
	T	6. 00	7. 00					
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		_					
1.00	Land	118, 000	0					1. 00
2.00	Land Improvements	0	0					2. 00
3.00	Buildings and Fixtures	5, 054, 443	0					3. 00
4.00	Building Improvements	0	0					4. 00
5.00	Fi xed Equi pment	0	0					5.00
6.00	Movable Equipment	3, 132, 139	0					6. 00
7.00	Subtotal (sum of lines 1-6)	8, 304, 582	0					7. 00
8.00	Reconciling Items	0	0					8. 00
9. 00	Total (line 7 minus line 8)	8, 304, 582	0					9. 00

Provi der No.: 315176

Peri od: Worksheet A-8

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

				10 12/31/2021	4/20/2022 9:59	
				Expense Classification on		, (,,,,
				To/From Which the Amount is		
				TOTTO III WITH CIT THE AMOUNT TS	to be haj astea	
	Diti (1)	(2) D!- F	A +-	C+ C+	1 : N-	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adj ustment	0.00	0.00		
	I	1.00	2. 00	3. 00	4. 00	
1. 00	Investment income on restricted funds	В	-2, 688	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
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)		0		0.00	6. 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
	physici an adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
	Capital expenditures (chapter 24)		_			
12.00	Adjustment resulting from transactions with	A-8-1	3, 744			12. 00
	related organizations (chapter 10)		-,			
13. 00	Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals	В	_10	DI ETARY	8.00	
15. 00	Cost of meals - Guests		10	DILIAKI	0.00	15. 00
16. 00	Sale of medical supplies to other than	•	0		0.00	16. 00
10.00	patients		0		0.00	10.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts	В	16	ADMINISTRATIVE & GENERAL	4.00	18. 00
19. 00	Vending machines	ь	-10	ADMINISTRATIVE & GENERAL	0.00	19.00
			0		1	
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		0.00	21. 00
	and borrowings to repay Medicare					
00.00	overpayments			UTILLI ZATLON, DEVILEW, CNE	00.00	00.00
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
00.00	(chapter 21)			OAD DEL COCTO DI DOC A	1 00	00.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
			_	FIXTURES	!	
24. 00	Depreciationmovable equipment		0	*** Cost Center Deleted ***	2.00	24. 00
25. 00	Other adjustment (specify)	_	0		0.00	25. 00
25. 02	WAREHOUSE INCOME	В	-10, 000	CAP REL COSTS - BLDGS &	1.00	25. 02
				FI XTURES		
25. 03	BAD DEBTS	A		ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	PUBLIC RELATIONS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 07	LOST PROPERTY REIMBURSEMENT	A		ADMINISTRATIVE & GENERAL	4.00	
25.08	TAUNTON ROAD AND FARM EXPENSE	A	-29, 257	ADMINISTRATIVE & GENERAL	4.00	25. 08
25.09	NJ CORPORATE BUSINESS TAX	A	-2	ADMINISTRATIVE & GENERAL	4.00	25. 09
25. 10	MANAGEMENT CONSULTANT FEES	A	-364, 576	ADMINISTRATIVE & GENERAL	4.00	25. 10
100.00	Total (sum of lines 1 through 99) (Transfer		-919, 400			100.00
	to Worksheet A, col. 6, line 100)					
(1) D-		Lump postoin to	CMC Dub 1E 1	•		•

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

Health Financial Systems MEDFORD NRSG& COSTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME MEDFORD NRSG& CONVA. CENTER

OFFICE COSTS

OFFICE COSTS					e Prepared: 2 9:59 am
	Line No.	Cost (Center	Expense Items	
	1. 00	2.	00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			G FACILITY	MEDICAL SUPPLIES MAINTENANCE SERVICE	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
	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: 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 12.	ED AS A RESULT 6, 108 5, 475 0 0 0 0 11, 583	2, 364 5, 475 0 0 0 0 0	3, 744 C C C C C C C		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

OFFICE COSTS

Provider No.: 315176

Parts I-II

From 01/01/2021 Date/Time Prepared: 4/20/2022 9:59 am 12/31/2021

	Symbol (1)	Name	Percentage of	
			Ownershi p	
	1.00	2. 00	3. 00	
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ATION(S) AND/O	R 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.

To parposes of oral mility for mount comont and or	0 /			
1.00	G	R. PINELES	0.00	1. 00
2.00	G	R. PINELES	0.00	2. 00
3.00			0.00	3. 00
4. 00			0.00	4. 00
5. 00			0.00	5. 00
6.00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			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 LATERDEL 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		JERSEY HC RESOURCES	0.00	MEDICAL SUPPLIER	1. 00
2.00		FRANKLIN UNIVERSAL BLDG CORP	0.00	MAI NTENANCE	2. 00
3.00			0.00		3. 00
4.00			0.00		4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10. 00
100.00	G. Other (financial or non-financial)		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.

A. CENTER In Lieu of Form CMS-2540-10
Provider No.: 315176 Period: Worksheet B
From 01/01/2021 Part I
To 13/31/2021 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					rom 01/01/2021 o 12/31/2021	Date/Time Pre	
			CAPI TAL			4/20/2022 9: 5	9 alli
			RELATED COSTS	5MD1 0V55			
	Cost Center Description	Net Expenses for Cost	BLDGS & FLXTURES	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	
		Allocation	TIXTURES	DENLITIS		& GLINERAL	
		(from Wkst A					
		col . 7)	1.00	0.00		4.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	3. 00	3A	4. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	1, 323, 453	1, 323, 453				1.00
3.00	00300 EMPLOYEE BENEFITS	993, 671	24, 821	1, 018, 492			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 362, 941	56, 117	89, 127			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	590, 373	44, 104	25, 693	· ·		5. 00
6.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	125, 727	30, 955	19, 296			6.00
7. 00 8. 00	00800 DI ETARY	387, 741 1, 040, 585	16, 954 189, 365	66, 440 105, 564			7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	587, 679	0	110, 191			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	15, 779	0	2, 959			10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13. 00	01300 SOCI AL SERVI CE	103, 297	0	19, 368			13. 00
15. 00	01500 RECREATION	172, 618	0	29, 941	202, 559	32, 051	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	3, 493, 792	914, 023	457, 739	4, 865, 554	769, 871	30.00
31. 00	03100 NURSING FACILITY	0,475,772	914, 023	437, 737	4, 003, 334	707, 071	31.00
32. 00	03200 CF/IID	0	Ö	0	0	Ö	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS				1		
40.00	04000 RADI OLOGY	15, 384	0	0			40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	21, 757 10, 273	0	0			41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	10, 273	0	0	10, 273		43.00
44. 00	04400 PHYSI CAL THERAPY	279, 364	38, 935	52, 381			44. 00
45.00	04500 OCCUPATI ONAL THERAPY	158, 380	0	29, 697			45. 00
46. 00	04600 SPEECH PATHOLOGY	53, 844	0	10, 096	63, 940		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	4, 692 259, 071	0	0	4, 692 259, 071		48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	259,071	0	0		40, 443	50.00
51. 00	05100 SUPPORT SURFACES	0	Ö	0	_		51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0			60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	18, 866	0	0			71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS				T	T	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	11, 029, 973	1, 315, 274	1, 018, 492	11, 021, 794	1, 505, 327	89. 00
	NONREI MBURSABLE COST CENTERS	_			,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	2, 369	0	0			90.00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	7, 513	8, 179	0	15, 692		•
92. 00 93. 00	09300 NONPALD WORKERS		0	0	0	0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY		0	Ö	o	Ö	94. 00
98. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	11, 039, 855	1, 323, 453	1, 018, 492	11, 039, 855	1, 508, 185	100. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provi der No.: 315176

				To	12/31/2021	Date/Time Prep 4/20/2022 9:59	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	7 alli
	oust defiter beschiptron	OPERATION.	LINEN SERVICE	HOUSEREEFTING	DIEIMIN	ADMI NI STRATI ON	
		MAINT. &	LINEN GENTIGE				
		REPAI RS					
		5. 00	6.00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	764, 628					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	19, 750	223, 573				6.00
7.00	00700 HOUSEKEEPI NG	10, 817	0	556, 499			7. 00
8.00	00800 DI ETARY	120, 821	0	91, 596	1, 759, 248		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	808, 293	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13. 00	01300 SOCI AL SERVI CE	0	0	0	0	0	13.00
15. 00	01500 RECREATION	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		T				
30. 00	03000 SKILLED NURSING FACILITY	583, 180	223, 573		1, 759, 248		30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0		31. 00
32. 00	03200 CF/ D	0	0	0	0	_	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1	1			1	
40. 00	04000 RADI OLOGY	0	0	0	0		40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	24, 842	0	18, 833	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	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	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	ıj U	0	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC			0	0		61. 00
62. 00	06200 FOHC				0		62. 00
02.00	OTHER REIMBURSABLE COST CENTERS	l .					02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE		Ō	o	0		71. 00
73. 00	07300 CMHC	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS	•	•				
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	759, 410	223, 573	552, 543	1, 759, 248	808, 293	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	5, 218	0	3, 956	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
98. 00	Cross Foot Adjustments	0	0	0	0		98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	764, 628	223, 573	556, 499	1, 759, 248	808, 293	100. 00

Provi der No.: 315176

| Period: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 4/20/2022 9:59 am

						4/20/2022 9:5	9 am
					OTHER GENERAL		
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	RECREATION	Subtotal	
		SERVICES &	RECORDS &				
		SUPPLY	LI BRARY				
		10.00	12.00	13. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	21, 703					10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	21,705	(12. 00
13. 00	01300 SOCIAL SERVICE			142, 074			13. 00
15. 00	01500 RECREATION		(1	234, 610		15. 00
13.00	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	234,010		15.00
30. 00	03000 SKILLED NURSING FACILITY	9, 830	C	142, 074	224 410	9, 838, 347	30.00
	1	1			234, 610		ı
31.00	03100 NURSING FACILITY	0	C		U	0	31.00
32. 00	03200 CF/ I D	0	C	0	U	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0) 0	U	0	33. 00
	ANCILLARY SERVICE COST CENTERS	ام			اء	17.010	
40. 00	04000 RADI OLOGY	0	C	_	0	17, 818	40. 00
41. 00	04100 LABORATORY	0	(0	0	25, 200	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	C	0	0	11, 898	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	0	0	12, 377	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	C	0	0	473, 007	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	C	0	0	217, 836	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	C	0	0	74, 057	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	C	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	5, 434	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	11, 873	C	0	0	311, 937	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	C	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	C	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	o	C	o o	0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>					1
70.00	07000 HOME HEALTH AGENCY COST	0	C	0	0	0	70. 00
71.00	07100 AMBULANCE	o	C	ol o	0	21, 851	71. 00
73.00		o	C	ol o	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS	-			-		
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 HOSPI CE		(0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	21, 703		142, 074	234, 610	11, 009, 762	1
07.00	NONREI MBURSABLE COST CENTERS	21,703		142,074	234, 010	11,007,702	0 7. 00
90. 00			(1 0	n	2, 744	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		(0	27, 349	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFICES				0	27, 347	92.00
	09300 NONPALD WORKERS	0			0	0	1
93. 00 94. 00	09400 PATIENTS LAUNDRY		(0	0	93. 00 94. 00
98.00			C	ή	O O	0	
	, , , , , , , , , , , , , , , , , , , ,			,	0		98.00
99.00	Negative Cost Centers	21 700	(142 074	224 (10	11 020 055	99.00
100.00	D TOTAL	21, 703	C	142, 074	234, 610	11, 039, 855	1100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MEDFORD NRSG& CONVA. CENTER

Provi der No.: 315176

Cost Center Description					4/20/2022 9:	59 am
GENERAL SERVICE COST CENTERS 1.00 18.00		Cost Center Description	Post Stepdown	Total		
ENPRAL SERVICE COST CENTERS 1,00 0.000 (CAP RELL COSTS - BUDGS & I FITURES 1,00 0.000 (CAP RELL COSTS - BUDGS & I FITURES 2,00 0.000 (ENPLOYEE BENEFITS 4,00 0.000 (ADM MIN STRATE YE & GENERAL 4,00 0.000 (ADM MISS MAC ARM NI STRATE ON 5,00						
1.00			17. 00	18. 00		
3.00			1			
4.00						
5.00						
0.000 0.000 LANDRY & LINEN SERVICE 0.0000 0.0000 0.0000 0.000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000						1
7. 00 007000 HOLDEKEEPING						
8. 00 000000 DIETARY						
9, 00 00900 NURSING ADMINISTRATION 10, 00 1000 CENTRAL SERVICES A LIBRARY 11, 00 1100 OT 0100 CENTRAL SERVICES 11, 00 115, 00						
10. 00 01000 CENTRAL SERVICES & SUPPLY 12. 00 1						
12. 00 01200 MEDICAL RECORDS & LI BRARY 13. 00						
13. 00 01300 SOCIAL SERVICE 15. 00 1						
15. 00						
IMPATI ENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SILLED NURSI NG FACILITY	15. 00					15. 00
31 00 03100 NURSI NG FACILITY 0 0 0 32.00 03200 IGF/II D 0 0 0 32.00 033.00 03300 IGF/II D 0 0 0 0 32.00 033.00 03300 IGF/II D 0 0 0 0 0 0 0 033.00 03300 IGF/II D 0 0 0 0 0 033.00 03300 IGF/II D 0 0 0 0 0 0 033.00 03300 IGF/II D 0 0 0 0 0 033.00 03300 IGF/II D 0 0 0 0 0 0 033.00 03300			1			
32.00 03200 ICF/I ID 32.00 33.00 3			1			
33.00 03300 071ER LONG TERM CARE 0 0 0 0 0 0 0 0 0			1	-		
ANCILLARY SERVICE COST CENTERS						
40.00	33. 00		0	0		33. 00
41.00			1			
42.00 04200 INTRAVENOUS THERAPY 0 11,898 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0 12,377 43.00 44.00 04400 PHYSI CAL THERAPY 0 473,007 44.00 45.00 04500 OCCUPATI ONAL THERAPY 0 217,836 45.00 46.00 04600 SPEECH PATHOLOGY 0 74,057 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 5,434 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 311,937 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51.00 05100 SUPPORT SUFFACES 0 0 0 00 00000 CLINIC CARE - TITLE XIX ONLY 0 0 0 00 05100 SUPPORT SUFFACES 0 0 0 00 00000 CLINIC COST CENTERS 0 0 0 01 06100 RURAL HEALTH CLINIC 0 0 0 0 02 06200 FOHC 0 0 0 0 03 07300 OMHC HEALTH AGENCY COST 0 0 0 0 07300 OMHC HEALTH AGENCY COST 0 0 0 0 07300 OMHC HEALTH AGENCY COST 0 0 0 0 07300 OMHC HEALTH AGENCY COST 0 0 0 0 07300 OMHC CARE - THE XER MEDICARD THE			i i			
43. 00 04300 0XYGEN (I NHALATION) THERAPY 0 12, 377 44. 00 04400 PHYSI CAL THERAPY 0 473, 007 44. 00 04400 PHYSI CAL THERAPY 0 217, 836 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 74, 057 46. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		· ·	0			
44. 00 04400 PHYSI CAL THERAPY 0 473,007 45.00 45.00 04500 0CCUPATI ONAL THERAPY 0 217,836 45.00 45.00 04600 SPEECH PATHOLOGY 0 0 0 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 04900 DRUGS CHARGED TO PATI ENTS 0 5,434 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 311,937 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0			
45. 00 04500 OCCUPATI ONAL THERAPY 0 217, 836 45. 00 46. 00 04600 SPECH PATHOLOGY 0 74, 057 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5, 434 48. 00 49. 00 04900 RUGS CHARGED TO PATIENTS 0 311, 937 49, 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 00 0TPATIENT SERVICE COST CENTERS 60. 00 06000 CLINIC 60. 00 61. 00 06100 RURAL HEALTH CLINIC 0 0 0 62. 00 06200 FOHC 60. 00 62. 00 06200 FOHC 60. 00 63. 00 07100 AMBULANCE 0 21, 851 71. 00 73. 00 07300 CMHC 70. 00 74. 00 07100 AMBULANCE 0 21, 851 71. 00 75. 00 07300 CMHC 70. 00 80. 00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81. 00 08300 HOSPICE REST EXPENSE 81. 00 82. 00 08200 UTILIZATION REVIEW - SNF 82. 00 83. 00 08300 DESPICAL SUMPORE SHOPS & CANTEEN 90. 00 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90. 00 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 27, 349 91. 00 92. 00 09200 PYISI CLINIS FLOWERS 90. 00 93. 00 9300 NONPEI TIBURSABLE COST CENTERS 90. 00 94. 00 09400 PATIENTS LAUNDRY 0 0 0 95. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 94. 00 09400 PATIENTS LAUNDRY 0 0 0 95. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 94. 00 09400 PATIENTS LAUNDRY 0 0 0 95. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 96. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CENTERS 90. 00 97. 00 90300 NONPEI TIBURSABLE COST CE			0			
46. 00 04600 SPECH PATHOLOGY 0 74,057 0 47.00 47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 47.00 47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 47.00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5,434 48.00 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 311,937 49.00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 5100 SUPPORT SURFACES 0 0 0 0 0 5100 SUPPORT SURFACES 0 0 0 0 0 61.00 GAIND CONTROL OF CONT		l l	0			
47. 00 04700 CLECTROCARDIOLOGY 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5,434 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 311, 937 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 311, 937 49. 00 05000 DRUTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0			
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5,434 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 311,937 49. 00 500 05000 DRUGS CHARGED TO PATIENTS 0 311,937 49. 00 550. 0			0			
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 311, 937 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 550. 00 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 51. 00 OUTPATIENT SERVICE COST CENTERS 60. 00 06000 CLINIC 0 0 0 61. 00 61. 00 06200 FOHC 0 0 0 61. 00 62. 00 07100 AMBULSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	٧,		
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0			
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0			0			
OUTPATLENT SERVICE COST CENTERS O			1			
60. 00	51. 00		0	0		51. 00
61. 00						
62. 00 06200 FOHC 0THER REI MBURSABLE COST CENTERS 70. 00 7000 HOME HEALTH AGENCY COST 0 0 70. 00 71. 00 7100 AMBULANCE 0 21, 851 71. 00 73. 00 SPECIAL PURPOSE COST CENTERS 80. 00 881.00 1NTEREST EXPENSE 82.00 82. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 83. 00 08300 HOSPI CE 80.00 89. 00 SUBTOTALS (sum of lines 1-84) 0 11, 009, 762 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 27, 349 91. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 27, 349 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 92. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 93. 00 94. 00 09000 Cross Foot Adjustments 0 0 99. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00 99. 00 Physic I ANS PRI VATE OFFI CES 0 0 0 0 99. 00 99. 00 Physic I ANS PRI VATE OFFI CES 0 0 0 0 99. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00			i i			
OTHER REIMBURSABLE COST CENTERS OTO00 HOME HEALTH AGENCY COST O O O O OTION AMBULANCE O OTION AMBULANCE O OTION OTION AMBULANCE O O O O OTION OTION OTION OTION AMBULANCE O O O O OTION OTIO			0	0		
70. 00	62. 00					62.00
71. 00				_		
73. 00 07300 CMHC 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 00 81. 00 08100 INTEREST EXPENSE 81. 00 82. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 83. 00 08300 HOSPI CE 0 0 0 89. 00 SUBTOTALS (sum of lines 1-84) 0 11, 009, 762 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 27, 349 91. 00 09100 BARBER AND BEAUTY SHOP 0 27, 349 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 93. 00 09300 NONPAI D WORKERS 0 0 94. 00 09400 PATI ENTS LAUNDRY 0 0 98. 00 09400 Negati ve Cost Centers 0 0 99. 00 0 0 0 99. 00 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0			1			
SPECIAL PURPOSE COST CENTERS S0.00			i i			
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 00 08100 INTEREST EXPENSE 81. 00 82. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 83. 00 08300 HOSPI CE 90. 00 90. 0	73. 00		0	0		73.00
81. 00			1			
82. 00 83. 00 83. 00 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 91. 00 91. 00 91. 00 92. 00 992. 00 992. 00 993. 00 993. 00 993. 00 994. 00 994. 00 994. 00 994. 00 995. 00 996. 00						
83. 00 89. 00 SUBTOTALS (sum of lines 1-84)						
89. 00 SUBTOTALS (sum of lines 1-84) 0 11,009,762 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 2,744 90.00 91. 00 09100 BARBER AND BEAUTY SHOP 0 27,349 91.00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 92.00 93. 00 09300 NONPAI D WORKERS 0 0 93.00 94.00 98. 00 PATI ENTS LAUNDRY 0 0 94.00 98. 00 Cross Foot Adjustments 0 0 98.00 99. 00 Negati ve Cost Centers 0 0 99.00				_		
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 2,744 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 27,349 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 92.00 93.00 NONPAI D WORKERS 0 0 0 93.00 09400 PATI ENTS LAUNDRY 0 0 0 94.00 98.00 Cross Foot Adjustments 0 0 0 0 99.00 Negati ve Cost Centers 0 0 0 99.00 0 0 0 0 0 0 0 0 0						
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 2,744 90. 00 91. 00 92. 00 09100 BARBER AND BEAUTY SHOP 0 27,349 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 93. 00 94. 00 94. 00 94. 00 95. 00 09400 PATI ENTS LAUNDRY 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0	89. 00	SUBIOTALS (sum of Tines 1-84)	0	11, 009, 762		89.00
91. 00 09100 BARBER AND BEAUTY SHOP 0 27, 349 91. 00 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 93. 00 94. 00 98. 00 0 0 0 0 0 0 0 0 0			1 _1			
92. 00 99.00			١			
93. 00 09300 NONPAI D WORKERS 0 0 0 93. 00 94. 00 98. 00 98. 00 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 99. 00 0 99. 00 0 0 0 0 0 0 0 0 0			0	1		
94.00 9400 PATIENTS LAUNDRY 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 99.00 99.00			0			
98.00 Cross Foot Adjustments 0 0 98.00 99.00 Negative Cost Centers 0 0 99.00			0	-1		
99.00 Negative Cost Centers 0 0 99.00			0	9		
		1 1	0	0		
100.00 101AL 0 11,039,855 100.00				0		
	100.00	D TOTAL	0	11, 039, 855		1100.00

| 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.: 315176

				To	12/31/2021	Date/Time Prep 4/20/2022 9:59	
	Cost Center Description	Directly Assigned New	CAPITAL RELATED COSTS BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	2 Cili
		Capi tal					
		Related Costs 0	1.00	2A	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS		1.00	Zn	3.00	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS	0	24, 821		24, 821		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	56, 117 44, 104		2, 172 626		4. 00 5. 00
5. 00 6. 00	00600 LAUNDRY & LINEN SERVICE		30, 955	· ·	470		6. 00
7. 00	00700 HOUSEKEEPI NG	0	16, 954		1, 619		7. 00
8.00	00800 DI ETARY	0	189, 365	189, 365	2, 572	8, 167	8. 00
9.00	00900 NURSING ADMINISTRATION	0	0	0	2, 685		9. 00
10. 00 12. 00	01000 CENTRAL SERVICES & SUPPLY 01200 MEDICAL RECORDS & LIBRARY	0	0	0	72 0		10. 00 12. 00
12.00	01300 SOCIAL SERVICE	0	0	0	472		12.00
15. 00	01500 RECREATION	0	Ö	0	730		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	1 ,		11, 157	29, 756	30. 00
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0		0	0	32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS						33.00
40.00	04000 RADI OLOGY	0	0	0	0	94	40. 00
41. 00	04100 LABORATORY	0	0	-	0	133	
42. 00	+ I	0	0	0	0	63	42.00
43. 00 44. 00	04300 0XYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	38, 935	38, 935	0 1, 276	65 2, 267	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	_	724		45. 00
46.00	1 1	0	0	0	246		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00		0	0	0	0	29	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0		0	0	1, 584	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	Ö		0		51. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	1		0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00		0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	115	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		Γ			Ι	80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	+ +						82. 00
83.00	08300 H0SPI CE	0	0	0	0		83. 00
89. 00		0	1, 315, 274	1, 315, 274	24, 821	58, 179	89. 00
00 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		1 0		0	14	90. 00
91.00		0	8, 179	8, 179	0	96	
92. 00		0	0, 1, 7	0,,	0	0	
93. 00		0	0	0	0	0	93. 00
94.00	I I	0	0	0	0	0	94. 00
98. 00 99. 00		-		0	0	0	98. 00 99. 00
100.00		0	1, 323, 453	1, 323, 453	24, 821		
	-1 1	1	1 ., 525, 100	1 ., 525, 100	2.,021	1 55, 267	

Provi der No.: 315176

				10	12/31/2021	Date/lime Pre 4/20/2022 9:5	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, diii
	·	OPERATI ON,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS	/ 00	7.00	0.00	0.00	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	48, 767	,				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 260	33, 761				6. 00
7.00	00700 HOUSEKEEPI NG	690	0	22, 144			7. 00
8.00	00800 DI ETARY	7, 706	0	3, 645	211, 455	i e	8. 00
9. 00	00900 NURSING ADMINISTRATION	C	0	0	0	6, 952	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		0	0	0	0	10.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE			0	0	0 0	12. 00 13. 00
15. 00	01500 RECREATION				0		15. 00
13.00	I NPATIENT ROUTINE SERVICE COST CENTERS		,	١			13.00
30. 00	03000 SKILLED NURSING FACILITY	37, 194	33, 761	17, 593	211, 455	6, 952	30. 00
31.00	03100 NURSING FACILITY	C	0	0	0	0	31. 00
32.00	03200 CF/IID	C	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	C	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	C		0	0		40. 00
41. 00	04100 LABORATORY	C	_	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	C		0	0	0	42.00
43. 00 44. 00	04300 0XYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	1 504	0	0 749	0	0	43. 00 44. 00
45. 00	04500 OCCUPATIONAL THERAPY	1, 584	0	749	0		45. 00
46. 00	04600 SPEECH PATHOLOGY				0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY		o o	Ö	0	Ö	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	C	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0	0	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	C	0	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS	1					
60.00	06000 CLINIC	C	0	0	0		60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	_) 	١	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST		0	ol	0	0	70. 00
71. 00	07100 AMBULANCE				0		71. 00
73.00	07300 CMHC	C	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF				0		82.00
83. 00 89. 00	08300 HOSPI CE	48, 434	33, 761	21, 987	211, 455	0 6, 952	83. 00 89. 00
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	40, 434	33, 701	21, 90/	211, 433	0, 932	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	o	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	333	1	157	0	0	91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES		l .	0	0	0	92.00
93.00	09300 NONPALD WORKERS	C	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	C	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00		10.7(7	1	0	0	0	99. 00
100.00	D TOTAL	48, 767	33, 761	22, 144	211, 455	6, 952	100. 00

Provi der No.: 315176

				''	0 12/31/2021	4/20/2022 9:5	9 am
			<u> </u>		OTHER GENERAL		
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	RECREATI ON	Subtotal	
		SERVICES &	RECORDS &				
		SUPPLY 10.00	12. 00	13. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	10.00	12.00	13.00	13.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTU	RES					1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REP.	AIRS					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 NURSI NG ADMI NI STRATI ON	107					9. 00
10.00	l l	187	0				10.00
12. 00 13. 00	l l	0	0	1 222			12.00
15. 00	l l		0		1, 969		13. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENT	FRS		0	1, 707		13.00
30. 00		85	0	1, 222	1, 969	1, 265, 167	30. 00
31. 00	1	0	0		0	0	31. 00
32. 00	1	o o	0		o	0	32. 00
33. 00	1	l ol	0		o	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	94	40. 00
41.00	04100 LABORATORY	0	0	0	0	133	41. 00
42.00	1 1	0	0	0	0	63	•
43. 00	, ,	0	0	0	0	65	
44. 00	1 1	0	0	0	0	44, 811	
45. 00	1 1	0	0	0	0	1, 874	
46. 00	1 1	0	0	0	0	637	46.00
47. 00	1 1	ATI ENTS	0	0	0	0	47. 00
48. 00 49. 00	1 1	102	0	0	0	29 1, 686	48. 00 49. 00
50.00	1 1	0	0		0	1, 080	50.00
51. 00	1 1		0		0	0	51.00
01.00	OUTPATIENT SERVICE COST CENTERS	I			o _l		01.00
60.00		0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	o	0	0	0	0	61. 00
62.00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	l l	0	0		0	0	70. 00
71. 00		0	0		0	115	
73. 00			0	0	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID L	OCCEC					80. 00
81. 00		033L3					81.00
82. 00							82. 00
83. 00	1 1	ol	0	0	0	0	
89. 00	l l	187	0	1, 222	1, 969	1, 314, 674	
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS &	CANTEEN O	0		0	14	
91. 00	l l	0	0	0	0	8, 765	
92.00	1 1	0	0	0	0	0	92. 00
93. 00	1 1	0	0		0	0	93. 00
94. 00	l l	l Ö	0	0	0	0	
98. 00 99. 00	1 1		^		0	0	98. 00 99. 00
100.00		187	0		٥	1, 323, 453	
100.00	o _l 10me	1 107	O	1,222	1, 707	1, 525, 455	1.00.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MEDFORD NRSG& CONVA. CENTER

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: Provi der No.: 315176

COST CENTER DESCRIPTION AGUS STOP-DOWN ADUST NETWORK					To 12/31/2021 Date/lime Pro 4/20/2022 9:5	
GENERAL SERVICE COST CENTERS		Cost Center Description	Post Step-Down	Total	172072022 7.10	3 / dill
CEMERAL SERVICE COST CENTERS		· ·	Adjustments			
1.00			17. 00	18. 00		
3.00 0.0300 EMPLOYEE RENEFITS						
4.00 00000 ADMINISTRATIVE & GENERAL 5.00 00000 DAND (PART OPERATION, MAINT. & REPAIRS 6.00 00000 DAND (PARTON) 000000 DAND (PARTON) 000000 DAND (PARTON) 000000 DIETARY 8.00 00000 DIETARY 9.00 00000 DIETARY 9.00 00000 DIETARY 9.00 010000 CRYTRAL SERVICES & SUPPLY 10.00 10.00 010000 REPAIR OF SUPPLY 10.00 1						
5.00 0.0500 PLANT OPERATION, MAINT. & REPAIRS 5.00 0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000						•
6.00 00000 LAUNDRY & LINEN SERVICE 6.00 0						
7. 00						•
8. 00						
9.00 10.00 01000 (DURISHA ISPRITION 10.00 110.00 01000 (ENTRAL SERVICES & SUPPLY 12.00 115.00 01500 (ENTRAL SERVICES & LIBRARY 13.00 115.00 01500 (SCIOLAL RECORDS & LIBRARY 13.00 117.00 01500 (MISSING FACILITY 0 0 1, 265, 167) 117.00 01500 (MISSING FACILITY 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 0 0 32.00 117.00 01500 (MISSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
10.00 01000 COLONIAL SERVICES & SUPPLY 12.00						
12.00 01200 MEDICAL RECORDS & LIBRARY						
13. 00 01300 SOCIAL SERVICE 15. 00 1						
15. 00 O1500 RECREATION						1
30.00						
31.00 03100 NURSI NG FACILITY 0 0 0 32.00 03200 ICF/II 0 0 0 0 32.00 033.00 CF/II 0 0 0 0 0 32.00 033.00 03300 CF/II 0 0 0 0 0 0 0 0 0		I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u> </u>		
32.00 03200 10FZ 10 0 0 32.00	30.00	03000 SKILLED NURSING FACILITY	0	1, 265, 167		30. 00
33.00 03300 0714ER LONG TERM CARE	31.00	03100 NURSING FACILITY	0	0		31.00
ANCILLARY SERVICE COST CENTERS	32.00			0		32. 00
40. 00 04000 RADIOLOGY 41. 00 04100 LABORATORY 41. 00 41. 00 04100 LABORATORY 41. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 43. 00 44. 00 44. 00 44. 00 44. 00 44. 01 45. 00 45. 00 46. 00 47. 00 48. 00 49. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 4	33. 00		0	0		33. 00
41.00 04100 LABORATORY						
42.00 04200 INTRAVENOUS THERAPY 0 6.3 4.2 .00 43.00 04300 OXYGEN (INHALATION) THERAPY 0 6.5 4.3 .00 44.00 04400 PHYSI CAL THERAPY 0 44,811 44,00 45.00 04500 OCCUPATI ONAL THERAPY 0 1,874 45.00 46.00 044600 SPECEN PATHOLOGY 0 6.37 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2.9 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 1,686 49.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 51.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00						
43. 00 04300 0XYGEN (I NHALATION) THERAPY 0 65 44. 00 04400 PHYSICAL THERAPY 0 44. 811 44. 00 45. 00 04500 0CCUPATIONAL THERAPY 0 1,874 45. 00 46. 00 04600 0FECH PATHOLOGY 0 637 46. 00 04600 0700						
44, 00 04400 PHYSICAL THERAPY 0 44, 811 45, 00 450 00 04500 0CCUPATI ONAL THERAPY 0 1, 874 45, 00 04600 SPEECH PATHOLOGY 0 0 637 46, 00 04600 SPEECH PATHOLOGY 0 0 0 47, 00 04700 ELECTROCARDI OLOGY 0 0 0 47, 00 04700 ELECTROCARDI OLOGY 0 0 0 0 47, 00 04900 DRUGS CHARGED TO PATIENTS 0 29 48, 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 686 49, 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0		1				•
45. 00 04500 OCCUPATI ONAL THERAPY 0 1,874 45. 00 046. 00 04600 SPECH PATHOLOGY 0 0637 46. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		, ,	1 1			
46. 00 47. 00 470 0 64700 ELECTROCARDIOLOGY 47. 00 47. 00 470 0 64700 ELECTROCARDIOLOGY 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 50. 00 60. 0		1	-			
47. 00 04700 ELECTROCARDI OLOGY 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 29 48. 00 04900 DRUGS CHARGED TO PATIENTS 0 1.686 49. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			1 -1			•
48. 00		1	1 -1			
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 1,686 50. 00 50. 00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 -1	- 1		•
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			1 -1			
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0			-			
OUTPATIENT SERVICE COST CENTERS 60.00 60000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-			
60. 00 06000 CLINIC 0 0 0 0 06100 RURAL HEALTH CLINIC 0 0 0 0 061.00 62. 00 06200 FOHC 0 07000 HOME HEALTH AGENCY COST 0 0 115 071.00 71. 00 07100 AMBULANCE 0 115 071.00 73. 00 07300 CMHC 0 0 0 0 73. 00 SPECIAL PURPOSE COST CENTERS 80. 00 80800 MALPRACTICE PREMI WIMS & PAI D LOSSES 81. 00 81. 00 08200 UTI LI ZATI ON REVIEW - SNF 82. 00 83. 00 08300 HOSPI CE 0 0 0 83. 00 SUBTOTALS (sum of lines 1-84) 0 1, 314, 674 89. 00 89. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90. 00 91. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 98. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00	01.00			0		31.00
61. 00	60.00		0	0		60.00
OTHER REIMBURSABLE COST CENTERS O				O		•
70. 00	62. 00	06200 FQHC				62.00
71. 00		OTHER REIMBURSABLE COST CENTERS				
73. 00 07300 CMHC 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTICE PREMI UMS & PAID LOSSES 81. 00 08100 INTEREST EXPENSE 81. 00 82. 00 08200 UTILLIZATION REVIEW - SNF 82. 00 83. 00 08300 HOSPICE 0 0 0 0 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 1,314,674 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 09100 BARBER AND BEAUTY SHOP 0 8,765 91. 00 92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 93. 00 09300 NONPAID WORKERS 0 0 094. 00 PATIENTS LAUNDRY 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00 0 99. 00 0 0 0 0 0 0 0 0 0	70.00	07000 HOME HEALTH AGENCY COST	0	0		70. 00
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 HOSPICE 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 0 1,314,674 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 14 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 8,765 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 99.00 99.00 99.00 0 99.00 0 99.00 0 99.00 0 99.00 0 99.00 0 99.00 0	71. 00	07100 AMBULANCE	0	115		71. 00
80. 00 80. 00 80. 00 MALPRACTICE PREMIUMS & PAID LOSSES 80. 00 81. 00 81. 00 82. 00 82. 00 83. 00	73. 00		0	0		73. 00
81. 00						
82. 00 83. 00 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 1,314,674 89. 00 NONREI MBURSABLE COST CENTERS 0 0 14 90. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 8,765 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 0 80. 00 0 0 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0 0 80. 00 0 0 0						•
83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 1,314,674 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 14 90. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 8,765 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 98. 00 099. 00 Negative Cost Centers 0 0 99. 00 Negative Cost Centers 0 0 99. 00 0 0 87. 00 0 0 88. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 99. 00 0						
89. 00 SUBTOTALS (sum of lines 1-84) 0 1,314,674 89. 00		1				
NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 14 90.00 91.00 91.00 91.00 92.00 91.00 92.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 93.00			1	1 214 (74		
90. 00 9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 14 90. 00 91. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 93. 00 93. 00 93. 00 93. 00 94. 00 94. 00 94. 00 94. 00 94. 00 94. 00 95	89. 00	SUBTUTALS (SUM OT TITNES 1-84)] 0	1, 314, 6/4		89.00
91. 00 09100 BARBER AND BEAUTY SHOP 0 8,765 92. 00 92. 00 93. 00 93. 00 94. 00 94. 00 94. 00 98. 00 98. 00 Nonpai be Rote Rote Rote Rote Rote Rote Rote Rot	00.00			1.4		90.00
92. 00 92.00 94.00 95.00			1 1			•
93. 00 93.00 09300 NONPAI D WORKERS 0 0 0 94.00 94.00 98.00 Cross Foot Adjustments 0 0 0 99.00 Negative Cost Centers 0 0 0 99.00 0 99.00 0 0 0 0 0 0 0 0 0						
94. 00 94. 00 94. 00 98. 00 99. 00			1			
98.00 Cross Foot Adjustments			١	n		
99.00 Negative Cost Centers 0 0 99.00			1 -1	n		
		1 1	1 -1	o		
	100.0	o TOTAL	0	1, 323, 453		100.00

Heal th	Fi nar	ncial Systems	MEDFORD NRSG& C	ONVA.	CENTER		In Lie	u of Form CMS-2	2540-10
COST A	LLOCA	TION - STATISTICAL BASIS		F	Provi der		Peri od:	Worksheet B-1	
							From 01/01/2021 o 12/31/2021	Date/Time Pre	nared:
						'	0 12/31/2021	4/20/2022 9:5	9 am
			CAPI TAL						
			RELATED COSTS						
		Cost Center Description	BLDGS &		LOYEE	Reconciliation	ADMI NI STRATI VE	PLANT	
			FI XTURES		EFITS		& GENERAL	OPERATI ON,	
			(SQUARE FEET)		ROSS		(ACCUM COST)	MAINT. &	
				SALA	ARI ES)			REPAIRS (SQUARE FEET)	
			1.00	3	. 00	4A	4. 00	5. 00	
	GENER	AL SERVICE COST CENTERS	1.00					0.00	
1.00		CAP REL COSTS - BLDGS & FIXTURES	46, 602						1.00
3.00	00300	EMPLOYEE BENEFITS	874	5	, 431, 895				3. 00
4.00	00400	ADMINISTRATIVE & GENERAL	1, 976		475, 340	-1, 508, 185	9, 531, 670		4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	1, 553		137, 026	(660, 170	42, 199	5. 00
6.00		LAUNDRY & LINEN SERVICE	1, 090		102, 910	(175, 978	1, 090	
7.00		HOUSEKEEPI NG	597		354, 345			597	7. 00
8.00		DI ETARY	6, 668		563, 000		.,	6, 668	
9. 00		NURSING ADMINISTRATION	0		587, 679			0	
		CENTRAL SERVICES & SUPPLY	0		15, 779	1		0	10.00
		MEDICAL RECORDS & LIBRARY	0		0	(0	12.00
		SOCIAL SERVICE	0		103, 297		,	0	13.00
15. 00		RECREATION IENT ROUTINE SERVICE COST CENTERS	0		159, 686	(202, 559	0	15. 00
30. 00	03000	SKILLED NURSING FACILITY	32, 185	2	, 441, 245		4, 865, 554	32, 185	30.00
		NURSING FACILITY	32, 183	2	, 441, 245 0			32, 183	
		ICF/IID	0		0			0	
		OTHER LONG TERM CARE	0		0			0	
00.00		LARY SERVICE COST CENTERS	<u> </u>				,ı		00.00
40.00		RADI OLOGY	0		0	(15, 384	0	40.00
41.00	04100	LABORATORY	0		0	(21, 757	0	41. 00
42.00	04200	I NTRAVENOUS THERAPY	O		0	(10, 273	0	42. 00
43.00	04300	OXYGEN (INHALATION) THERAPY	0		0	(10, 686	0	43. 00
	1	PHYSI CAL THERAPY	1, 371		279, 364		370, 680	1, 371	
		OCCUPATI ONAL THERAPY	0		158, 380			0	
46. 00		SPEECH PATHOLOGY	0		53, 844			0	
		ELECTROCARDI OLOGY	0		0	(-	0	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	(.,	0	48. 00
		DRUGS CHARGED TO PATIENTS	0		0			0	49.00
50.00		DENTAL CARE - TITLE XIX ONLY	0		0	(0	
51. 00		SUPPORT SURFACES TIENT SERVICE COST CENTERS	0			(0	0	51.00
60. 00		CLINIC	O		0		ol	0	60.00
		RURAL HEALTH CLINIC	0		0			0	
	06200		1		Ü	Ì	1	ū	62. 00
		REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0		0	(0	0	70. 00
71. 00	07100	AMBULANCE	0		0	(18, 866	0	71. 00
	07300		0		0	(0	0	73. 00
		AL PURPOSE COST CENTERS	T			T	T T		
		MALPRACTICE PREMIUMS & PAID LOSSES							80.00
		INTEREST EXPENSE							81.00
82. 00		UTILIZATION REVIEW - SNF HOSPICE			0	,		0	82.00
83. 00 89. 00	06300	SUBTOTALS (sum of lines 1-84)	46, 314	5	, 431, 895	-1, 508, 185	9, 513, 609	0 41, 911	1
07.00	NONRE	IMBURSABLE COST CENTERS	40, 314	<u> </u>	, 431, 073	-1, 500, 160	9, 513, 609	41, 711	09.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	(2, 369	0	90.00
		BARBER AND BEAUTY SHOP	288		0			288	1
		PHYSICIANS PRIVATE OFFICES	0		0			0	
93.00	09300	NONPALD WORKERS	0		0	(o	0	93. 00
94.00	09400	PATIENTS LAUNDRY	0		0	(o	0	94. 00
98. 00		Cross Foot Adjustments							98. 00
99. 00		Negative Cost Centers							99. 00
102.00)	Cost to be allocated (per Wkst. B,	1, 323, 453	1	, 018, 492		1, 508, 185	764, 628	102. 00
100.00		Part I)	20, 2000/3		0 107500		0.450000	40 440577	102.00
103.00	1	Unit cost multiplier (Wkst. B, Part I)	28. 399060		0. 187502		0. 158229	18. 119576	
104. 00	<u>'</u>	Cost to be allocated (per Wkst. B, Part II)			24, 821		58, 289	48, 767	104. 00
105.00		Unit cost multiplier (Wkst. B, Part			0. 004569		0. 006115	1. 155643	105.00
. 55. 50		II)					5. 555115		5.00
	•	•	•				'		

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315176

Period: Worksheet B-1 From 01/01/2021

12/31/2021 Date/Time Prepared: 4/20/2022 9:59 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG CENTRAL LINEN SERVICE (MEALS SERVED) ADMINISTRATION SERVICES & (SQUARE FEET) (PATI ENT **SUPPLY** CENSUS) (DI RECT (COSTED REQUIS.) NURSI NG) 6.00 7.00 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 00300 EMPLOYEE BENEFITS 3.00 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 41, 503 6.00 6.00 00700 HOUSEKEEPI NG 40, 512 7.00 7 00 8.00 00800 DI ETARY 0 6,668 124, 509 8.00 9.00 00900 NURSING ADMINISTRATION 0 111, 492 9.00 0 01000 CENTRAL SERVICES & SUPPLY 473, 559 10 00 Ω 0 10 00 01200 MEDICAL RECORDS & LIBRARY 0 12.00 C 0 0 0 12.00 13.00 01300 SOCIAL SERVICE 0 C 0 0 0 13.00 01500 RECREATION 15.00 0 0 0 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 41,503 32, 185 124, 509 111, 492 214, 488 30.00 03100 NURSING FACILITY 31.00 0 0 31.00 0 03200 | CF/IID 32 00 0 0 0 32 00 0 0 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 C 0 40.00 04100 LABORATORY 0 0 0 41.00 C 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42.00 C 0 0 42.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 43.00 0 44.00 04400 PHYSI CAL THERAPY 0 0 1.371 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 0 45 00 45.00 C 0 04600 SPEECH PATHOLOGY 46.00 0 0 Λ 46.00 04700 ELECTROCARDI OLOGY 0 0 0 0 47.00 47.00 0 0 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 0 259, 071 49 00 C 49 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 50.00 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 60.00 06000 CLI NI C 0 0 0 0 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 \cap O 0 Λ 70.00 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 73.00 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 0 Λ 83.00 89.00 SUBTOTALS (sum of lines 1-84) 41,503 40, 224 124, 509 111, 492 473, 559 89.00 NONREI MBURSABLE COST CENTERS 90.00 90 00 09000 GLET. FLOWER. COFFEE SHOPS & CANTEEN 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 288 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 C 0 92.00 0 09300 NONPALD WORKERS ol 93.00 93.00 0 0 0 94.00 09400 PATIENTS LAUNDRY 0 C 0 0 0 94.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 102 00 Cost to be allocated (per Wkst. B, 223 573 556, 499 1, 759, 248 808 293 21, 703 102. 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 5. 386912 13.736646 14. 129485 7. 249785 0.045830 103.00 104.00 Cost to be allocated (per Wkst. B, 33, 761 22, 144 211, 455 6, 952 187 104. 00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.813459 0.546603 1.698311 0.062354 0.000395 105.00 II)

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315176 Peri od:

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

Date/Time Prepared:

12/31/2021

4/20/2022 9:59 am OTHER GENERAL SERVI CE Cost Center Description MEDI CAL SOCIAL SERVICE RECREATI ON RECORDS & (CENSUS) LI BRARY (PATI FNT (PATI ENT CENSUS) CENSUS) 12.00 13.00 15.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS - BLDGS & FLXTURES 1 00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 01200 MEDICAL RECORDS & LIBRARY 41, 503 12.00 12.00 01300 SOCIAL SERVICE 13.00 13.00 41, 503 01500 RECREATION 15.00 41,503 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 41,503 41, 503 41, 503 30.00 03100 NURSING FACILITY 31.00 31.00 C 32 00 03200 LCE/LLD 0 C 0 32 00 33.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 0 0 41.00 04100 LABORATORY C 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 00000000 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 44.00 0 0 44.00 04500 OCCUPATIONAL THERAPY 0 45.00 C 45.00 04600 SPEECH PATHOLOGY 46.00 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS C 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 49.00 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 61.00 61.00 C 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 07100 AMBULANCE 0 0 71 00 C 71 00 07300 CMHC 73.00 0 C 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81 00 81 00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 83.00 89.00 SUBTOTALS (sum of lines 1-84) 41,503 41,503 41, 503 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 90.00 0 0 09100 BARBER AND BEAUTY SHOP 0 0 91.00 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 92.00 0 09300 NONPALD WORKERS 0 0 93.00 C 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 94.00 98.00 Cross Foot Adjustments 98.00 99 00 Negative Cost Centers 99 00 102.00 Cost to be allocated (per Wkst. B, 142,074 234, 610 102.00 3. 423222 103.00 103.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 5.652844 104.00 104.00 Cost to be allocated (per Wkst. B, 1.969 1. 222 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.029444 0.047442 105.00

MEDEODD NDCC0 CONV	CENTED		1 1:-	6 F CMC (DE 40, 10
Heal th Financial Systems MEDFORD NRSG& CONVA				u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der		Period: From 01/01/2021	Worksheet C	
			To 12/31/2021	Date/Time Prep	nared:
			12/01/2021	4/20/2022 9:59	9 am
Cost Center Description		Total (from	Total Charges	Ratio (col. 1	
		Wkst. B, Pt I	,	di vi ded by	
		col . 18)		col. 2	
		1.00	2. 00	3.00	
ANCILLARY SERVICE COST CENTERS					
40. 00 04000 RADI OLOGY		17, 81			40.00
41. 00 04100 LABORATORY		25, 20	0 28, 006	0. 899807	41.00
42.00 04200 INTRAVENOUS THERAPY		11, 89	8 5, 716	2. 081526	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY		12, 37	7 10, 686	1. 158244	43.00
44. 00 O4400 PHYSI CAL THERAPY		473, 00	7 549, 511	0. 860778	44.00
45. 00 04500 0CCUPATI ONAL THERAPY		217, 83	629, 699	0. 345937	45.00
46. 00 04600 SPEECH PATHOLOGY		74, 05	7 211, 795	0. 349664	46.00
47. 00 04700 ELECTROCARDI OLOGY			0	0. 000000	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		5, 43	4, 692	1. 158142	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS		311, 93	7 292, 137	1. 067776	49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY			0	0. 000000	50.00
51. 00 05100 SUPPORT SURFACES			0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS					
60. 00 06000 CLI NI C			0	0. 000000	60.00
61. 00 06100 RURAL HEALTH CLINIC					61.00
62. 00 06200 FQHC					62.00
71. 00 07100 AMBULANCE		21, 85	1 0	0.000000	71. 00
100. 00 Total		1, 171, 41	5 1, 747, 297		100. 00
		•	•	·	

Health Financial Systems	MEDFORD NRSG& (CONVA. CENTER		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 4/20/2022 9:5	pared: 9 am
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pr	rogram Charges	s Health Care	Program Cost	
Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2. 00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	1. 183527			0 8, 760	0	
41. 00 04100 LABORATORY	0. 899807			0 1, 088	0	
42. 00 04200 I NTRAVENOUS THERAPY	2. 081526			0 6, 282	0	
43. 00 O4300 OXYGEN (INHALATION) THERAPY	1. 158244			0 357	0	
44. 00 O4400 PHYSI CAL THERAPY	0. 860778			0 215, 158	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 345937			0 96, 710	0	1 .0.00
46. 00 04600 SPEECH PATHOLOGY	0. 349664			0 40, 979	0	1 .0.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 158142			0 745	0	1
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 067776			0 144, 443	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS		_		_	_	
60. 00 06000 CLI NI C	0. 000000	0		0	0	
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62. 00
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of lines 40 - 71)		794, 568		0 514, 522	0	100. 00

⁽¹⁾ For title V and XIX use columns 1, 2, and 4 only.

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

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS Provider No.: 315176 Period: From 01/01/2021 To 12/31/2021 Parts II - III Date/Time Prep 4/20/2022 9:59 Title XVIII Skilled Nursing Facility PPS Cost Center Description PART II - APPORTIONMENT OF VACCINE COST 1.00 Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) Program vaccine charges (From your records, or the PS&R) 3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18) Cost Center Description Total Cost (From Wkst. B, Allied Health (From Wkst. B, Part I, Col. 18 Part I, Col. From O1/01/2021 Parts II - III Date/Time Prep 4/20/2022 9:59 Program of 1.00 1.00 1.00 PART II - APPORTIONMENT OF VACCINE COST 1.00 1.00 POST Column 3, line 49 1.067776 1.407 1.502 E, Part I, line 18 Cost Center Description From Wkst. B, Allied Health (From Wkst. B, Part I, Col. 18 Part I, Col. 18 Provider No.: 315176 From 01/01/2021 Total Cost Nursing & Allied Health (Cost Cost (From Wkst. D Part A) Program Part A Part A Nursing Worksheet D Parts II - III Date/Time Prep 4/20/2022 9:59 Program Part A (Cost (From Wkst. D) Program Part A) Program Part A Part A Nursing Worksheet D Parts II - III Date/Time Prep 4/20/2022 PES Part II - OI Date/Time Program Part A (Cost (From Wkst. D) Program Part A) Program Part A Part A Nursing Part I, Col. Part I, Col. (Cost (From Wkst. D) Part I,	red:
Cost Center Description PART II - APPORTIONMENT OF VACCINE COST 1.00 Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) 2.00 Program vaccine charges (From your records, or the PS&R) 3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18) Cost Center Description Total Cost (From Wkst. B, Allied Health Nursing & Ratio of (From Wkst. B, Allied Health Nursing & Allied Health Nursing & Allied Health Realth Nursing & Restriction (From Wkst. B, Allied Health Realth Realth Costs) 1.00 1.00 1.067776 2.00 Program Part A Part A Nursing & Ratio of (From Wkst. B, Allied Health Realth Realth Realth) Part I, Col. (Costs to Total I, Col. 4) For Pass	
PART II - APPORTIONMENT OF VACCINE COST 1.00 Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) 2.00 Program vaccine charges (From your records, or the PS&R) 3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18) Cost Center Description Total Cost (From Wkst. B, Allied Health (From Wkst. B) (F	
PART II - APPORTIONMENT OF VACCINE COST 1.00 Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) Program vaccine charges (From your records, or the PS&R) 3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18) Cost Center Description Total Cost (From Wkst. B, Allied Health Nursing & Cost (From Wkst. D Part I, Col. (From Wkst. B, Allied Health Part I, Col. Costs to Total I, Col. 4) Part I, Col. (Costs to Total I, Col. 4) For Pass	
Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) 2.00 Program vaccine charges (From your records, or the PS&R) 3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18) Cost Center Description Total Cost (From Wkst. B, Allied Health Nursing & Cost (From Wkst. D Part I, Col. (From Wkst. B, Allied Health Part I, Col. Costs to Total I, Col. 4) Total Cost (From Wkst. B, Allied Health Part I, Col. Costs to Total I, Col. 4) Total Cost (From Wkst. B, Allied Health Part I, Col. Costs to Total I, Col. 4) Total Cost (From Wkst. B, Allied Health Part I, Col. Costs to Total I, Col. 4)	
3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet 1,502	1.00
E, Part I, line 18) Cost Center Description Total Cost (From Wkst. B, Part I, Col. (From Wkst. B, Allied Health Part I, Col. (From Wkst. B, Part I, Col. (From Wkst. B, Allied Health Part I, Col. (From Wkst. B, Allied Health Part I, Col. (From Wkst. D Part I) (From Wkst. D Par	2.00
Cost Center Description Total Cost Nursing & Ratio of Program Part A Part A Nursing Cost (From Wkst. B, Allied Health Nursing & Cost (From Wkst. D Part Costs Part Col. Costs to Total I, Col. 4) For Pass	3.00
(From Wkst. B, Allied Health Nursing & Cost (From & Allied Part I, Col. (From Wkst. B, Allied Health Wkst. D Part Health Costs 18 Part I, Col. Costs to Total I, Col. 4) for Pass	
Part I, Col. (From Wkst. B, Allied Health Wkst. D Part Health Costs Part I, Col. Costs to Total I, Col. 4) for Pass	
18 Part I, Col. Costs to Total I, Col. 4) for Pass	
14) Costs - Part A Through (Col.	
(Col. 2 / Col. 3 x Col. 4)	
(cost 2 / cost 1)	
1.00 2.00 3.00 4.00 5.00	
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH	
ANCI LLARY SERVI CE COST CENTERS	
	10.00
	1.00
	2.00
	3. 00
11.11.11.11.11.11.11.11.11.11.11.11.11.	4.00
	15.00
	16. 00 17. 00
	17. 00 18. 00
	O UU
	19. 00 50. 00
100.00 Total (Sum of Lines 40 - 52) 1,149,564 0 514,522 0	19. 00 50. 00 51. 00

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315176	Peri od: From 01/01/2021	Worksheet D-1 Parts I-II	
			To 12/31/2021	Date/Time Pre 4/20/2022 9:5	
		Title XVIII	Skilled Nursing Facility	PPS	, u
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			41, 503	
2.00	Private room days			0	
. 00 . 00	Inpatient days including private room days applicable to the Pr Medically necessary private room days applicable to the Program			4, 521 0	3. C
5. 00	Total general inpatient routine service cost	I		9, 838, 347	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			7, 030, 347	3.0
. 00	General inpatient routine service charges			13, 074, 721	6.0
7.00	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 752471	7.0
3. 00	Enter private room charges from your records			0	8.0
0.00	Average private room per diem charge (Private room charges line 2)	:8 divided by private	room days, line	0.00	9. 0
0. 00	Enter semi-private room charges from your records			0	
1. 00	Average semi-private room per diem charge (Semi-private room c	harges line 10, divide	d by	0.00	11. (
2 00	semi-private room days) Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12. (
2. 00	Average per diem private room cost differential (Line 7 times I			0.00	
4. 00					
5. 00				0 9, 838, 347	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS	•			
6. 00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		237. 05	16. 0
7. 00	Program routine service cost (Line 3 times line 16)			1, 071, 703	
8. 00				0	
9.00	Total program general inpatient routine service cost (Line 17		+ III 10	1, 071, 703	
0.00	Capital related cost allocated to inpatient routine service cosline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	its (From WKSt. B, Par	t II COLUMN 18,	1, 265, 167	
1. 00	Per diem capital related costs (Line 20 divided by line 1)			30. 48	
2. 00	Program capital related cost (Line 3 times line 21)			137, 800	
3.00		:: d-:		933, 903	
4.00	Aggregate charges to beneficiaries for excess costs (From prov		nuc line 24)	933, 903	
5. 00 6. 00		Timitation (Line 23 mi	nus i i ne 24)	933, 903	26.
	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27. (
	.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)				28. 0
	(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	ed for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH	1		١.
. 00	Total SNF inpatient days			41, 503	
2.00	Program inpatient days (see instructions)	complete for +: +! ac V	or VIV)	4, 521	2. C
3. 00 1. 00	Total nursing & allied health costs. (see instructions)(Do not Nursing & allied health ratio. (Line 2 divided by Line 1)	complete for titles v	UI AIA)	0 0 108932	
	Nursing & allied health ratio. (line 2 divided by line 1) Program nursing & allied health costs for pass-through. (line 3 times line 4) 0.108932				

Health Financial Systems	MEDFORD NRSG& CON\	/A. CENTER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	R TITLE XVIII	Provi der No.: 315176	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 4/20/2022 9:59 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMFNT		1.00	
1.00	Inpatient PPS amount (See Instructions)	LIVICIAI		2, 900, 331	1.00
2. 00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	
3.00	Subtotal (Sum of lines 1 and 2)	J		2, 900, 331	3. 00
4.00	Primary payor amounts			0	4. 00
5. 00	Coinsurance			488, 422	5. 00
6.00	Allowable bad debts (From your records)			126, 215	
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		90, 893	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)	,		82, 040	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			2, 493, 949	11. 00
12.00	Interim payments (See instructions)			2, 529, 174	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			0	14. 99
15.00	Balance due provider/program (see Instructions)			-35, 225	15. 00
16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)				0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - T	TITLE XVIII ONLY		
17. 00	Ancillary services Part B				17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			1, 502	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			1, 502	
20.00	Medicare Part B ancillary charges (See instructions)			1, 407	•
21. 00	Cost of covered services (Lesser of line 19 or line 20)			1, 407	
22. 00	Primary payor amounts			0	
23. 00	Coinsurance and deductibles			0	
24. 00	Allowable bad debts (From your records)	ations)		0	24. 00
24. 01 24. 02	Allowable Bad debts for dual eligible beneficiaries (see instru	Ctrons)		0	24. 01 24. 02
25. 00	Adjusted reimbursable bad debts (see instructions) Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			1, 407	
26. 00	Interim payments (See instructions)			1, 195	
27. 00	Tentative adjustment			1, 143	
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			212	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2. s	section 115.2	0	
	1			٥١	

From 01/01/2021 12/31/2021 Date/Time Prepared: 4/20/2022 9:59 am

8.00

Title XVIII Skilled Nursing

PPS Facility Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3. 00 2, 487, 709 1.00 Total interim payments paid to provider 1, 195 1.00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 05/21/2021 41, 465 0 3. 01 3.02 0 3.02 C 0 0 3 03 3.03 0 3.04 0 3.04 3.05 0 0 3.05 Provider to Program 3 50 ADJUSTMENTS TO PROGRAM 3.50 0 0 3.51 0 0 3.51 0 0 3. 52 3.52 3.53 0 0 3.53 3.54 0 0 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 41, 465 0 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2, 529, 174 1, 195 4.00 (Transfer to Wkst. E, Part I line 12 for Part A, and line 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 PROVIDER 0 0 5.01 0 5.02 0 5.02 5.03 5.03 0 0 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5.51 0 Ω 5 52 5 52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 PROGRAM TO PROVIDER 212 6.01 0 PROVIDER TO PROGRAM 35, 225 6.02 Ω 6.02 Total Medicare program liability (see instructions) 2, 493, 949 1, 407 7.00 Contractor Contractor Name Number 1.00 2 00

8.00 Name of Contractor

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

ealth Financial Systems MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-2540-10

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

Provider No.: 315176 | Period: From 01/01/202

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

onl y)			10 12/31/20	4/20/2022 9:5	
		General Fund	Specific Endowment Fu		
		1.00	Purpose Fund 3.00	4. 00	
	Assets				
4 00	CURRENT ASSETS	074 007		ما	4 00
1. 00 2. 00	Cash on hand and in banks	374, 327	0 0	0 0	
3.00	Temporary i nvestments Notes receivable	0			
4. 00	Accounts receivable	2, 213, 932	1		
5. 00	Other recei vabl es	-765	<u> </u>		
6. 00	Less: allowances for uncollectible notes and accounts	-184, 453		ol c	
	recei vabl e				
7.00	Inventory	0	0	0 0	7. 00
8.00	Prepai d expenses	664, 272	0	0 0	
9.00	Other current assets	0	0	0 0	
10.00	Due from other funds	0	0	0 0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	3, 067, 313	0	0 0	11. 00
12 00	FIXED ASSETS	110,000	O	0 0	12 00
12. 00 13. 00	Land Land improvements	118, 000		0 0	
14. 00	Less: Accumulated depreciation		o o		
15. 00	Bui I di ngs	5, 054, 443	- T		1
16. 00	Less Accumulated depreciation	-5, 053, 288	•	ol c	
17. 00	Leasehold improvements	0	O	o c	1
18.00	Less: Accumulated Amortization	0	О	o c	18. 00
19.00	Fi xed equipment	0	О	0 0	19. 00
20.00	Less: Accumulated depreciation	0	0	0 0	20. 00
21. 00	Automobiles and trucks	75, 701	0	0 0	1
22. 00	Less: Accumulated depreciation	-75, 701	0	0 0	
23. 00	Major movable equipment	3, 056, 438		0 0	1
24. 00	Less: Accumulated depreciation	-3, 046, 094	1	0 0	
25. 00	Mi nor equi pment - Depreci abl e	0	0	0 0	
26. 00 27. 00	Minor equipment nondepreciable Other fixed assets	(20 (4)	0	0 0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	638, 646 768, 145	•		
20.00	OTHER ASSETS	700, 143	y y	<u> </u>	20.00
29. 00	Investments	0	O	ol c	29. 00
30. 00	Deposits on Leases	l o	o	ol c	
31. 00	Due from owners/officers	-2, 791, 710	o	ol c	
32.00	Other assets	0	О	o c	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-2, 791, 710	О	0 0	33. 00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	1, 043, 748	0	0 0	34.00
	Liabilities and Fund Balances				1
25 00	CURRENT LI ABI LI TI ES	2 254 (01			35 00
35. 00	Accounts payable	2, 354, 601	0	0 0	
36. 00 37. 00	Salaries, wages, and fees payable Payroll taxes payable	316, 403 1, 174			
38. 00	Notes & Loans payable (Short term)	1, 1/4			
39. 00	Deferred income	115, 248	Ö		
40. 00	Accel erated payments	0		٦	40.00
41.00		0	О	o c	41.00
42.00	Other current liabilities	157, 755	О	0 0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 945, 181	0	0 0	43.00
	LONG TERM LIABILITIES				
44. 00	Mortgage payable	4, 846, 369		0 0	1
45. 00	Notes payable	0	0	0 0	1
46.00	Unsecured Loans	0	0	0 0	1
47. 00	Loans from owners:	2, 185, 179	0	0 0	
48. 00 49. 00	Other long term liabilities OTHER (SPECIFY)	0		0 0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	7, 031, 548	· -		1
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	9, 976, 729			
01.00	CAPI TAL ACCOUNTS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>	<u> </u>	1
52.00	General fund balance	-8, 932, 981			52.00
53.00	Specific purpose fund		O		53.00
54.00	Donor created - endowment fund balance - restricted			0	54.00
55.00	Donor created - endowment fund balance - unrestricted			0	55.00
56. 00	Governing body created - endowment fund balance			0	56. 00
57. 00	Plant fund balance - invested in plant			C	
58. 00	Plant fund balance - reserve for plant improvement,			C	58. 00
59. 00	replacement, and expansion TOTAL FUND BALANCES (Sum of Lines 52 thru 58)	-8, 932, 981	0	o c	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	1, 043, 748			
00.00	[59]	1,043,740	T		1 55. 50
		•	'	•	•

MEDFORD NRSG& CONVA. CENTER

Provider No.: 315176 | Period: | Worksheet G-1 | To | 12/31/2021 | To | 12/31/2021 | From Office | Period: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					To		Date/Time Pr 4/20/2022 9:		
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fun	d	
		1.00	2.00	3. 00		4. 00	5. 00		
1.00	Fund balances at beginning of period		-10, 595, 144			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		1, 662, 162 -8, 932, 982			0			2. 00 3. 00
4. 00	Additions (credit adjustments)		-0, 732, 702			0			4. 00
5. 00	ROUNDI NG	1			0			0	5. 00
6.00		0			0			0	6. 00
7.00		0			0		l .	0	7. 00
8. 00 9. 00		0			0			0	8. 00 9. 00
10.00	Total additions (sum of line 5 - 9)		1		U	0		~ I	10. 00
11. 00	Subtotal (line 3 plus line 10)		-8, 932, 981			0			11. 00
12.00	Deductions (debit adjustments)								12. 00
13. 00		0			0			- 1	13. 00
14.00		0			0				14.00
15. 00 16. 00		0			0				15. 00 16. 00
17. 00					0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0			0			18. 00
19. 00	Fund balance at end of period per balance		-8, 932, 981			0			19. 00
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund				+	
		Lildowillerit Turid	TTAIT	Tuna					
		6.00	7. 00	8. 00					
1.00	Fund balances at beginning of period	0			0				1. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)				0				2. 00 3. 00
4. 00	Additions (credit adjustments)				O				4. 00
5.00	ROUNDI NG		0					ı	5.00
6.00			0						6. 00
7.00			0						7. 00
8. 00 9. 00			0						8. 00 9. 00
10. 00	Total additions (sum of line 5 - 9)	o	· ·		0			ı	10. 00
11. 00	Subtotal (line 3 plus line 10)	o			0			İ	11. 00
12. 00	Deductions (debit adjustments)								12. 00
13.00			0						13.00
14. 00 15. 00			0						14. 00 15. 00
16. 00			0						16. 00
17. 00			0					- 1	17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0			0				18. 00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0			0				19. 00

	Financial Systems MEDFORD NRSG& CO		N 045477		eu of Form CMS-	
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315176	Peri od: From 01/01/202	Worksheet G-2 1 Parts I-II	!
				To 12/31/202	1 Date/Time Pre	
			1	L	4/20/2022 9:5	9 am
	Cost Center Description		Inpatient 1.00	Outpati ent 2.00	Total 3. 00	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Care Services					1
1.00	SKILLED NURSING FACILITY		13, 074, 7	21	13, 074, 721	1.00
2.00	NURSING FACILITY			0	0	1
3.00	ICF/IID			0	0	
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		13, 074, 7	21	13, 074, 721	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		1, 747, 29		0 1, 747, 296	6. 00
7.00	CLINIC				0 0	
8.00	HOME HEALTH AGENCY COST				0 0	
9.00	AMBULANCE				0 0	
10. 00					0 0	
10. 10					0 0	
11. 00					0 0	1
12. 00				0	0	
13. 00			123, 6	-	0 123, 623	1
14. 00		n 3 to	14, 945, 6	40	0 14, 945, 640	14. 00
	Worksheet G-3, Line 1) Cost Center Description					
	cost center bescription			1. 00	2.00	
	PART II - OPERATING EXPENSES			1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				11, 959, 255	1.00
2.00	Add (Specify)				ol	2.00
3.00					ol	3.00
4.00					ol	4.00
5.00					ol	5. 00
6.00					o	6.00
7.00					ol	7.00
8.00	Total Additions (Sum of lines 2 - 7)				0	8. 00
9.00	Deduct (Specify)				o	9. 00
10.00					o	10.00
11. 00					0	11. 00
12.00					0	12. 00
					0	13. 00
13. 00				1	1 0	14.00
14. 00	Total Deductions (Sum of lines 9 - 13) Total Operating Expenses (Sum of lines 1 and 8, minus line 1				11, 959, 255	

Health Financial Systems MEDFORD NRSG& CONVA. CENTER In	Lieu of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315176 Period:	Worksheet G-3
From 01/01/2	
To 12/31/2	
	4/20/2022 9:59 am
	1. 00
1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	14, 945, 640 1. 00
2.00 Less: contractual allowances and discounts on patients accounts	2, 774, 951 2.00
3.00 Net patient revenues (Line 1 minus line 2)	12, 170, 689 3. 00
4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)	11, 959, 255 4. 00
5.00 Net income from service to patients (Line 3 minus 4)	211, 434 5. 00
Other income:	
6.00 Contributions, donations, bequests, etc	0 6.00
7.00 Income from investments	2, 688 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 discounts	0 10.00
11.00 Rebates and refunds of expenses	0 11.00 0 12.00
12.00 Parking lot receipts 13.00 Revenue from Laundry and Linen service	17, 630 13. 00
14.00 Revenue from meals sold to employees and guests	10 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	16 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	896 21.00
22.00 Rental of skilled nursing space	0 22.00
23.00 Governmental appropriations	0 23.00
24.00 Other miscellaneous revenue (specify)	0 24.00
24. 01 PRI OR YEAR	-34, 005 24. 01
24. 02 NON PATIENT REVENUE	18, 000 24. 02
24. 03 BARBER BEAUTY	12, 193 24. 03
24. 50 COVI D-19 PHE Funding	1, 433, 300 24. 50
25. 00 Total other income (Sum of lines 6 - 24)	1, 450, 728 25. 00
26.00 Total (Line 5 plus line 25) 27.00 Other expenses (specify)	1, 662, 162 26. 00 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, 662, 162 31. 00
	, , , , , , , , , , , , , , , , , , , ,