12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315525 Worksheet S Parts I, II & III Peri od: From 01/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 6/1/2023 5: 35 pm PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 6/1/2023 Time: 5:35 pm use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[0]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code

for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

5. Date Received:

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 HARBOUR VIEW SENIOR LIVING CENTER (315525) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	2	SI GNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Si gnatory Ti tle			3
4	Date			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	0	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	0	0	0	100.00

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

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

Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315525 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 6/1/2023 5: 35 pm 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 3161 KENNEDY BOULEVARD PO Box: 1.00 2.00 City: NORTH BERGEN State: NJ Zi p Code: 07047 2.00 3.00 County: HUDSON CBSA Code: 35614 Urban/Rural: U 3.00 CBSA Code: 3. 01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF HARBOUR VIEW SENIOR 315525 01/05/2018 N Р 0 4.00 LIVING CENTER 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 45 000 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 45, 00d 23.00 23.00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Υ 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 2 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00

0

0

41.00

41.00 List malpractice premiums and paid losses:

Heal th	th Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu					2540-10
	D NURSING FACILITY AND SKILLED NURSING X INDENTIFICATION DATA	FACILITY HEALTH CARE	Provi der No.: 315525	Peri od: From 01/01/2022 To 12/31/2022		pared:
				'	Y/N 1.00	-
	Are malpractice premiums and paid losse center? Enter Y or N. If yes, check box amounts.				N	42. 00
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	pter 10?		N	43.00
	If line 43 is yes, enter the home office of lines 45, 46 and 47.	ce chain number and enter	the name and address	of the home		44. 00
	1.00	2. 00		3. 00		
	If this facility is part of a chain org below.	ganization, enter the name	e and address of the h	ome office on the	lines	
45.00	Name:	Contractor's Name:	Contrac	tor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47. 00	Ci ty:	State:	Zi p Cod	e:		47. 00

	Financial Systems HAR D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	BOUR VIEW SENIOR LI TY HEALTH CARE		No.: 315525	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre 6/1/2023 5:35	pared:
					Y/N 1,00	Date	
	General Instruction: For all column 1 responseresponses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" fo	r Yes or "N"	1.00 for No. For all	2.00 the date	
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter tinstructions)	y prior to the beg the date of the cha	inning of nge in col	the cost umn 2. (see	N		1.00
	This it does only			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Progr	am? If	1. 00 N	2. 00	3. 00	2.00
3. 00	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or firelationships? (see instructions)	of termination and tions, including ma , chain home offic d to the provider o , or members of th	in column nagement es, drug or its e board	Y			3. 00
				Y/N	Type	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	' for Audited, "C" te copy or enter da no, see instructio	for te ns.	Y	С	09/30/2023	4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If creconciliation.			N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
6. 00	Column 1: Were costs claimed for Nursing Schollegal operator of the program? (Y/N)	ool? (Y/N) Column 2	: Is the	provider the	N	N	6.00
7. 00 8. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin	ng the cost reporti		for Nursing	N N		
	Were costs claimed for Allied Health Programs	ng the cost reporti		for Nursing		Y/N	•
	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	ng the cost reporti		for Nursing		Y/N 1.00	
9. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt	ng the cost reporti ee instructions. d debts? (Y/N) see	ng period	ns.	N		9.00
9. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for back	ng the cost reporti ee instructions. d debts? (Y/N) see	ng period instruction change du	ns. ring this cos	N st reporting	1. 00 N	9. 00 10. 00
9. 00 10. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	ng the cost reporti ee instructions. d debts? (Y/N) see t collection policy	instruction change du	ns. ring this co Y", see instr ", see instru	st reporting ructions.	1.00 N N	9. 00 10. 00 11. 00
9. 00 10. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d debts? (Y/N) seet collection policy d/or coinsurance was	instruction change du	ns. ring this co: Y", see instr ", see instru	st reporting ructions. uctions. art A	N N N Part B	9. 00 10. 00 11. 00
9. 00 10. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	ng the cost reporti ee instructions. d debts? (Y/N) see t collection policy	instruction change du	ns. ring this co Y", see instr ", see instru	st reporting ructions.	1.00 N N	7. 00 8. 00 9. 00 10. 00 11. 00
9. 00 10. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	d debts? (Y/N) seet collection policy d/or coinsurance was cost reporting per	instruction change du	ns. ring this co: Y", see instr ", see instr P Y/N	st reporting ructions. uctions. art A Date	1.00 N N N Part B Y/N	9. 00 10. 00 11. 00
9. 00 10. 00 11. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bacterial line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and	d debts? (Y/N) seet collection policy d/or coinsurance was cost reporting per	instruction change du	ns. ring this co: Y", see instru ", see instru P Y/N 1.00	st reporting ructions. uctions. art A Date 2.00	1.00 N N N N Part B Y/N 3.00	9. 00 10. 00 11. 00 12. 00
9. 00 10. 00 11. 00 12. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bacterial line 9 is "Y", did the provider's bad debterial line 9 is "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used	d debts? (Y/N) seet collection policy d/or coinsurance was cost reporting per	instruction change du	ns. ring this co: Y", see instr ", see instr P Y/N 1.00	st reporting ructions. uctions. art A Date 2.00	1.00 N N N Part B Y/N 3.00	9. 00 10. 00 11. 00
9. 00 10. 00 11. 00 12. 00 13. 00 15. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so the second and seeking reimbursement for backline 9 is "Y", did the provider's bad debit period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	d debts? (Y/N) seet collection policy d/or coinsurance was cost reporting per	instruction change du	ns. ring this co: Y", see instru ", see instru P Y/N 1.00 N	st reporting ructions. uctions. art A Date 2.00	1.00 N N N N Part B Y/N 3.00 Y	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
9. 00 10. 00 11. 00 12. 00 13. 00 15. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so the second and secon	d debts? (Y/N) seet collection policy d/or coinsurance was cost reporting per	instruction change du	ns. ring this co: Y", see instr ", see instr P Y/N 1.00 Y	st reporting ructions. uctions. art A Date 2.00	1.00 N N N N Part B Y/N 3.00 Y	9. 00 10. 00 11. 00 12. 00

Heal th	Financial Systems HARBOUR VIEW SENI	OR LI	VING CENTER		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE		Provi der No.: 315525	Perio		Worksheet S-2	2
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				01/01/2022 12/31/2022		nared:
				10	12/31/2022	6/1/2023 5: 35	par eu.
			1. 00		2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position	CHAR	LES	REE)		19. 00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
20.00	Enter the employer/company name of the cost report	EXEC	UCARE ASSOCIATES				20. 00
	preparer.						
21. 00	Enter the telephone number and email address of the cost	(609)738-3200	CRW	ASSC@NETSCAF	PE. NET	21. 00
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems In Lieu of Form CMS-2540-10 HARBOUR VIEW SENIOR LIVING CENTER SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315525 Peri od: Worksheet S-2 From 01/01/2022 To 12/31/2022 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 6/1/2023 5: 35 pm Part B Date 4.00 PS&R Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to 05/25/2023 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 14.00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: 18.00

Health Financial Systems HARBOUR VIEW SENIOR SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Provi der No.: 315525

					0 12/31/2022	6/1/2023 5:35	
				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	60	21, 900		2, 611	11, 416	1. 00
2.00	NURSING FACILITY	0	0			0	2. 00
3.00	I CF/IID	O	0		0	0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	148	54, 020		U	U	4. 00 5. 00
6. 00	SNF-Based CMHC	140	54, 020				6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	208			2, 611	11, 416	8. 00
		Inpatient [Di scharges	·	
		0.11	-	T' 11 \	T' 11 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	T' 11 VIV	
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
1.00	SKILLED NURSING FACILITY	6. 00	7. 00 20, 266	8.00	9. 00	10. 00	1. 00
2.00	NURSING FACILITY	0, 239	20, 200	1	40	0	2. 00
3.00	ICF/IID	0	0	_		0	3. 00
4. 00	HOME HEALTH AGENCY COST	o o	Ö				4. 00
5.00	Other Long Term Care	16, 937	16, 937				5. 00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	1	0	0	7. 00
8.00	Total (Sum of lines 1-7)	23, 176			40	24	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	16			65. 28	475. 67	1.00
2.00	NURSING FACILITY	0	0			0.00	2.00
3.00	ICF/IID HOME HEALTH AGENCY COST	0	0			0.00	3.00
4. 00 5. 00	Other Long Term Care	0	0				4. 00 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)	16	80	0.00			8. 00
		Average Length		Admi s	si ons		
		of Stay	- 1	I	T1.11 V1.V	0.11	
	Component	Total 16. 00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
1. 00	SKILLED NURSING FACILITY	253. 33				20.00	1. 00
2.00	NURSING FACILITY	0.00			0	0	2. 00
3.00	ICF/IID	0.00			0	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	HOSPI CE	0.00	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	465.04 Admissions	Full Time	50 Equi val ent	10	19	8. 00
		Auiii 551 0115	ruii iiiie	Lqui vai erit			
	Component	Total	Employees on	Nonpai d			
		04.00	Payrol I	Workers			
1.00	SKILLED NURSING FACILITY	21.00	22. 00 92. 43	23.00			1. 00
2.00	NURSING FACILITY	0					2. 00
3.00	ICF/IID	0					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)	79	105. 89	0.00			8. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315525

Amount Reclass. of Salaries (col. Worksheet A-6 1 ± col. 2) Salary in col. Col. 4) PART II - DIRECT SALARIES SALARIES
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
PART II - DIRECT SALARIES
ISALARI ES
1.00 Total salaries (See Instructions) 4,556,291 0 4,556,291 220,256.00 20.69 1.00
2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2.00
3.00 Physician salaries-Part B 0 0 0 0.00 0.00 3.00
4.00 Home office personnel 0 0 0 0.00 0.00 4.00
5.00 Sum of lines 2 through 4 0 0 0 0.00 5.00
6.00 Revised wages (line 1 minus line 5) 4,556,291 0 4,556,291 220,256.00 20.69 6.00
7.00 Other Long Term Care 0 560,658 560,658 27,995.00 20.03 7.00
8.00 HOME HEALTH AGENCY COST 0 0 0.00 0.00 8.00
9.00 CMHC 0 0 0 0.00 0.00 9.00
10. 00 HOSPI CE 0 0 0 0. 00 0. 00 10. 00
11. 00 Other excluded areas 0 0 0 0.00 0.00 11. 00
12.00 Subtotal Excluded salary (Sum of lines 7 0 560,658 560,658 27,995.00 20.03 12.00
through 11)
13.00 Total Adjusted Salaries (line 6 minus line 4,556,291 -560,658 3,995,633 192,261.00 20.78 13.00
OTHER WAGES & RELATED COSTS
14.00 Contract Labor: Patient Related & Mgmt 139,270 0 139,270 2,344.00 59.42 14.00
15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00
16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16.00
WAGE-RELATED COSTS
17.00 Wage-related costs core (See Part IV) 804,095 0 804,095 17.00
18.00 Wage-related costs other (See Part IV) 0 0 18.00
19.00 Wage related costs (excluded units) 0 0 19.00
20.00 Physician Part A - WRC 0 0 0 20.00
21.00 Physician Part B - WRC 0 0 21.00
22.00 Total Adjusted Wage Related cost (see 804,095 0 804,095 22.00
instructions)

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315525

						6/1/2023 5: 35	pm
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1. 00
2.00	Administrative & General	2, 526, 998	-2, 195, 042	331, 956	9, 290. 00	35. 73	2. 00
3.00	Plant Operation, Maintenance & Repairs	129, 789	135, 524	265, 313	17, 195. 00	15. 43	3. 00
4.00	Laundry & Li nen Servi ce	0	0	C	0.00	0.00	4. 00
5.00	Housekeepi ng	53, 226	146, 991	200, 217	13, 125. 00	15. 25	5. 00
6.00	Di etary	267, 543	300, 768	568, 311	37, 984. 00	14. 96	6. 00
7.00	Nursing Administration	243, 585	70, 075	313, 660	7, 646. 00	41. 02	7. 00
8.00	Central Services and Supply	0	0	C	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	C	0.00	0.00	10.00
11.00	Soci al Servi ce	25, 814	24, 121	49, 935	1, 971. 00	25. 33	11. 00
12.00	Nursing and Allied Health Ed. Act.						12. 00
13.00	Other General Service	74, 359	77, 347	151, 706	9, 636. 00	15. 74	13.00
14.00	Total (sum lines 1 thru 13)	3, 321, 314	-1, 440, 216	1, 881, 098	96, 847. 00	19. 42	14. 00

SNF WAGE RELATED COSTS	Provi der No.: 315525	Peri od:	Worksheet S-3
		From 01/01/2022	Part IV
		To 12/31/2022	Date/Time Prepared:
			6/1/2023 5: 35 pm
			Amount
			Reported

2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2 3.00 Qualified and Non-Qualified Pension Plan Cost 0 3	pm
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 1 3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost 0 4	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost 0 4	
Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions Tax Sheltered Annuity (TSA) Employer Contribution 0 2 3.00 Qualified and Non-Qualified Pension Plan Cost 0 4 00 Prior Year Pension Service Cost 0 4	
RETIREMENT COST 1.00 401K Employer Contributions 0 1 2.00 Tax Shel tered Annuity (TSA) Employer Contribution 0 2 3.00 Qualified and Non-Qualified Pension Plan Cost 0 3 4.00 Prior Year Pension Service Cost 0 4	
1.00 401K Employer Contributions 0 1 2.00 Tax Shel tered Annuity (TSA) Employer Contribution 0 2 3.00 Qualified and Non-Qualified Pension Plan Cost 0 3 4.00 Prior Year Pension Service Cost 0 4	
2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2 3.00 Qualified and Non-Qualified Pension Plan Cost 0 3 4.00 Prior Year Pension Service Cost 0 4	
3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost 0 3	1.00
4.00 Prior Year Pension Service Cost 0 4	2.00
	3.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	4.00
5.00 401K/TSA Plan Administration fees 0 5	5.00
6.00 Legal /Accounting/Management Fees-Pension Plan 0 6	6.00
7.00 Employee Managed Care Program Administration Fees 0 7	7.00
HEALTH AND INSURANCE COST	
8.00 Health Insurance (Purchased or Self Funded) 143,924 8	8. 00
9.00 Prescription Drug Plan	9. 00
10.00 Dental, Hearing and Vision Plan	10.00
	11.00
	12. 00
	13.00
	14.00
	15.00
	16, 00
Non cumulative portion)	
TAXES	
17. 00 FI CA-Employers Portion Only 354, 719 17	17.00
18.00 Medicare Taxes - Employers Portion Only 5,746 18	18.00
	19.00
20.00 State or Federal Unemployment Taxes	20.00
OTHER	
21.00 Executive Deferred Compensation 0 21	21.00
	22. 00
23.00 Tuition Reimbursement	23.00
	24.00
Amount	
Reported	
1.00	
Part B - Other than Core Related Cost	
25. 00 OTHER WAGE RELATED COST 0 25	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No.: 315525 Period:

Peri od: Worksheet S-3 From 01/01/2022 Part V To 12/31/2022 Date/Ti me Prepared:

6/1/2023 5: 35 pm 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 3.00 5. 00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 458, 350 88. 356 546, 706 10, 215. 00 53, 52 1.00 Licensed Practical Nurses (LPNs) 512 330 98, 762 611, 092 15, 440. 00 39.58 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 1, 233, 553 237, 792 1, 471, 345 67, 443. 00 21.82 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 2, 204, 233 424, 910 2, 629, 143 93, 098. 00 28.24 4.00 5.00 Physical Therapists 1,025.00 49. 35 5.00 50, 588 42.412 8, 176 Physical Therapy Assistants 0.00 6.00 C 0.00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 50.90 8.00 9, 188 1, 117. 00 8.00 47 663 56, 851 0.00 9.00 C C 0.00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 65. 95 11.00 Speech Therapists 9,731 1,876 11,607 176.00 11.00 Respiratory Therapists 0.00 12.00 12 00 0 00 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 0 00 14 00 0.00 15.00 Licensed Practical Nurses (LPNs) 91, 545 91, 545 1, 540. 00 59.44 15.00 Certified Nursing Assistant/Nursing 870 30.00 29.00 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 92, 415 92, 415 1, 570. 00 58.86 17.00 18.00 Physical Therapists 461.00 60.02 18.00 27, 671 27, 671 19.00 Physical Therapy Assistants 0.00 0.00 19.00 0 Physical Therapy Aides 20.00 0.00 0.00 20.00 Occupational Therapists 58. 07 21.00 9, 465 163.00 21.00 9.465 Occupational Therapy Assistants 22.00 0 0.00 0.00 22.00 Occupational Therapy Aides 0.00 0.00 23.00 23.00 64. 79 24.00 Speech Therapists 9.719 9, 719 150.00 24.00 0.00 Respiratory Therapists 25.00 25.00 0 0.00 26.00 Other Medical Staff 0.00 0.00 26.00

From 01/01/2022 12/31/2022 Date/Time Prepared: 6/1/2023 5: 35 pm Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38, 00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB2 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 SE3 53.00 53.00 54.00 SE2 54.00 55.00 SE1 55.00 SSC 56.00 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 PE1 68.00 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75. 00 PA₂

Provi der No.: 315525

Peri od:

Health Financial Systems	HARBOUR VIEW SENIOR LIV	ING CENTE	R	In Lie	u of Form CMS	-2540-10		
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der		Peri od:	Worksheet S-	7		
				From 01/01/2022 To 12/31/2022				
				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 Staffi ng 102. 00 Recrui tment						101. 00 102. 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	, line 1, column 3)					106. 00		

0

0

0

4, 556, 291

4, 361

5, 445, 297

C

4, 361

10, 001, 588

C

0

0

0

0 92.00

0 93.00

0

10, 001, 588 100. 00

91.00

94 00

4, 361

0

0

0

0

90.00

91.00

92.00

100.00

09100 BARBER AND BEAUTY SHOP

93. 00 09300 NONPALD WORKERS

94. 00 09400 PATIENTS LAUNDRY

TOTAL

09200 PHYSICIANS PRIVATE OFFICES

 Health Financial
 Systems
 HARBOUR VIEW
 SENIOR LIVING CENTER

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No

Provi der No.: 315525

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 6/1/2023 5:35 pm

					3 5: 35 pm
	Cost Center Description	Adjustments to	Net Expenses		
	F		For Allocation		
		Wkst A-8)	(col. 5 +-		
			col. 6)		
		6.00	7.00	1	
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-539, 180	1, 040, 461		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT				2. 00
3.00	00300 EMPLOYEE BENEFITS	0	878, 316		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-878, 507			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	1	l .	6. 00
7. 00	00700 HOUSEKEEPI NG		264, 536		7. 00
8. 00	00800 DI ETARY		933, 401		8. 00
9. 00	00900 NURSING ADMINISTRATION				9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY				10.00
11. 00	01100 PHARMACY				11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0		12. 00
13. 00	01300 SOCIAL SERVICE		1		13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		1		14. 00
15. 00	01500 ACTIVITIES				15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		177,470	9	15.00
30. 00	03000 SKILLED NURSING FACILITY	0	2, 137, 630		30.00
31. 00	03100 NURSING FACILITY			1	31.00
32. 00	03200 CF/11D				32.00
33. 00	03300 OTHER LONG TERM CARE		 		33.00
33.00	ANCILLARY SERVICE COST CENTERS		J 500, 050		33.00
40. 00	04000 RADI OLOGY	0	1, 820		40. 00
41. 00	04100 LABORATORY				41. 00
42. 00	04200 I NTRAVENOUS THERAPY		4, 751		42.00
			1 403		•
43. 00	04300 OXYGEN (INHALATION) THERAPY		Ί		43. 00
44. 00	04400 PHYSI CAL THERAPY		86, 728		44.00
45. 00	04500 OCCUPATIONAL THERAPY		1		45. 00
46. 00	04600 SPEECH PATHOLOGY		19, 450	l .	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		1	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		19, 196		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	1,		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			50.00
51. 00	05100 SUPPORT SURFACES	0) 0)	51.00
40.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1) 0	<u></u>	40.00
60.00	· ·	0	l control of the cont	1	60.00
61. 00	06100 RURAL HEALTH CLINIC	0))	61.00
62. 00	06200 FOHC				62. 00
70.00	OTHER REIMBURSABLE COST CENTERS		N 0		70.00
70.00	07000 HOME HEALTH AGENCY COST	0	l control of the cont	l control of the cont	70.00
71. 00	07100 AMBULANCE	0	l control of the cont	I control of the cont	71. 00
/3.00	07300 CMHC	0) 0)	73. 00
00.00	SPECIAL PURPOSE COST CENTERS			J	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	l control of the cont	l control of the cont	80.00
81. 00		0		l e e e e e e e e e e e e e e e e e e e	81.00
	08200 UTILIZATION REVIEW - SNF	0	1		82. 00
83. 00	08300 H0SPI CE	0	1	l .	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 417, 687	8, 579, 540)	89. 00
00.05	NONREI MBURSABLE COST CENTERS	-	-	N.	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	•	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	4, 361	i e	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0	1	92.00
	09300 NONPALD WORKERS	0	0)	93. 00
	09400 PATIENTS LAUNDRY	0	1)	94. 00
100.00	D TOTAL	-1, 417, 687	8, 583, 901		100. 00

Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 6/1/2023 5:35 pm

				6/1/2023 5: 35	pm
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2.00	3.00	4. 00	5. 00	
(1) A - RECLASS P/R					
1.00	DI ETARY	8. 00	300, 768	0	1.00
2.00	HOUSEKEEPI NG	7. 00	146, 991	0	2.00
3.00	PLANT OPERATION, MAINT. & REPAIRS	5. 00	135, 524	0	3. 00
4.00	ACTI VI TI ES	15. 00	77, 347	0	4.00
5. 00	SOCI AL SERVI CE	13.00	24, 121	0	5.00
6.00	NURSING ADMINISTRATION	9. 00	70, 075	0	6.00
7. 00	SKILLED NURSING FACILITY	30.00	402, 907	0	7.00
8. 00	SKILLED NURSING FACILITY	30.00	422, 673	0	8.00
9. 00	OTHER LONG TERM CARE	33.00	560, 658	0	9.00
10. 00	PHYSI CAL THERAPY	44.00	11, 777	0	10.00
11. 00	OCCUPATI ONAL THERAPY	45. 00	39, 981	0	11.00
12. 00	SPEECH PATHOLOGY	46. 00	2, 220	0	12.00
(1) B - RECLASS LAB AND IV		<u> </u>	· '		ĺ
13. 00	LABORATORY	41. 00	0	4, 751	13.00
14. 00	I NTRAVENOUS THERAPY	42.00	o	463	14.00
(1) E - RECLASS MED SUPP		<u> </u>	'		ĺ
15. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	48. 00	0	19, 196	15. 00
TOTALS					1
100. 00	Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		2, 195, 042	24, 410	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.

					07 17 2020 0.00	
			Decreases			
		Cost Center	Li ne #	Sal ary	Non Salary	
		6. 00	7.00	8. 00	9. 00	
	(1) A - RECLASS P/R	·				
1.00		ADMINISTRATIVE & GENERAL	4.00	300, 768	0	1.00
2.00		ADMINISTRATIVE & GENERAL	4.00	146, 991	0	2.00
3.00		ADMINISTRATIVE & GENERAL	4.00	135, 524	0	3.00
4.00		ADMINISTRATIVE & GENERAL	4.00	77, 347	0	4.00
5.00		ADMINISTRATIVE & GENERAL	4.00	24, 121	0	5.00
6.00		ADMINISTRATIVE & GENERAL	4.00	70, 075	0	6.00
7.00		ADMINISTRATIVE & GENERAL	4.00	402, 907	0	7.00
8.00		ADMINISTRATIVE & GENERAL	4.00	422, 673	0	8.00
9.00		ADMINISTRATIVE & GENERAL	4.00	560, 658	0	9.00
10. 00		ADMINISTRATIVE & GENERAL	4.00	11, 777	0	10.00
11. 00		ADMINISTRATIVE & GENERAL	4.00	39, 981	0	11.00
12. 00		ADMINISTRATIVE & GENERAL	4.00	2, 220	0	12.00
	(1) B - RECLASS LAB AND IV			, -		
13. 00		SKILLED NURSING FACILITY	30.00	0	4, 751	13.00
14. 00		SKILLED NURSING FACILITY	30.00	o	463	14.00
	(1) E - RECLASS MED SUPP					
15. 00		CENTRAL SERVICES & SUPPLY	10.00	0	19, 196	15. 00
	TOTALS	·	·			ĺ
100.00				2, 195, 042	24, 410	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

Provi der No.: 315525

				'	7270172022	6/1/2023 5: 35	
	·			Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	784, 758	0	0	0	784, 758	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	1, 490, 553	0	0	0	1, 490, 553	6. 00
7.00	Subtotal (sum of lines 1-6)	2, 275, 311	0	0	0	2, 275, 311	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	2, 275, 311	0	0	0	2, 275, 311	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5	_				
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	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	0	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	0	0				7. 00
8. 00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	0	0				9. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

Provi der No.: 315525

Peri od:

Worksheet A-8

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 6/1/2023 5: 35 pm

					6/1/2023 5: 35	pm
				Expense Classification on	Worksheet A	
				To/From Which the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1.00	2.00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-408	ADMINISTRATIVE & GENERAL	4.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7.00	Parking Lot (chapter 21)	В	-7, 300	CAP REL COSTS - BLDGS &	1.00	7. 00
				FI XTURES		
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	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
40.00	Capital expenditures (chapter 24)		E04 000			40.00
12. 00	Adjustment resulting from transactions with	A-8-1	-531, 880			12. 00
12.00	related organizations (chapter 10)		0		0.00	12 00
13.00	Laundry and linen service		0		0.00	13.00
14. 00	Revenue - Employee meals		-			14.00
15.00	Cost of meals - Guests		0		0.00	
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
17. 00	patients Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	18. 00
19. 00	Vending machines		0		0.00	19. 00
20. 00	Income from imposition of interest, finance		0		0.00	20. 00
20.00	or penalty charges (chapter 21)		O		0.00	20.00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
21.00	and borrowings to repay Medicare		O		0.00	21.00
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
				EQUI PMENT		
25.00	MANAGEMENT FEE	Α	-171, 407	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	ADVERTI SI NG	A	-4, 069	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	ADVERTI SI NG	Α	-5, 256	ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	COMMI SSI ON EXPENSE	A	-18, 425	ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	MANAGEMENT FEE	A	-210, 000	ADMINISTRATIVE & GENERAL	4.00	25. 04
25. 05	MEALS & ENTERTAINMENT	A	-2, 023	ADMINISTRATIVE & GENERAL	4.00	25. 05
25. 06	REFERRAL SOURCE	A	-7, 750	ADMINISTRATIVE & GENERAL	4.00	25. 06
25. 07	TRAVEL	A	-220	ADMINISTRATIVE & GENERAL	4.00	25. 07
25. 08	MI LEAGE/GAS	A		ADMINISTRATIVE & GENERAL	4.00	25. 08
25. 09	UNCATEGORI ZED EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	25. 09
25. 10	OTHER REV. MI SC.	В		ADMINISTRATIVE & GENERAL	4.00	25. 10
25. 11	OTHER I NCOME	В		ADMINISTRATIVE & GENERAL	4.00	25. 11
25. 12	MARKETI NG P/R	A	-30, 149	ADMINISTRATIVE & GENERAL	4.00	25. 12
25. 13			0		0.00	25. 13
25. 14			0		0.00	
25. 15			0		0.00	
25. 16			0		0.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-1, 417, 687			100. 00
	to Worksheet A, col. 6, line 100)	<u> </u>		I	l	l

to Worksheet A, col. 6, line 100)

(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 HARBOUR VIEW SENIOR LIVING CENTER STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No | Peri od: | Worksheet A-8-1 | From 01/01/2022 | Parts I-I | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315525 OFFICE COSTS

Line No. Cost Center Expense Items 1.00 2.00 3							6/1/2023 5: 35	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 CAP REL COSTS - BLDGS & RENT 1.00 CAP REL COSTS - BLDGS & RENT 2.00 CAP REL COSTS - BLDGS & RENT 2.00 CAP REL COSTS - BLDGS & RENT 3.00 CAP REL COSTS - BLDGS & RENT 3								
1.00								
Second S							o OR	
Second S	1. 00				- BLDGS &	RENT		1. 00
4.00	2. 00				- BLDGS &	RENT		2. 00
5.00 6.00 7.00 8.00 7.00 8.00 7.00 8.00 9.00 10.00								
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. Amount Allowable In Cost Wkst. A, col. 10.00 PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.70 0.00 0.00 0.00 0.00 0.00 0								
7. 00 8. 00 9. 00 10. 0								1
8.00 9.00 10								11
9. 00 10.								
10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.								
Amount Amount Adjustments Col. 4 minus Col. 5 Sol. 5 Col. 5 Sol. 5 Col. 5 Sol. 5 Col. 6 Col. 7 Col. 6 Col. 7 Col. 6 Col. 6 Col. 6 Col. 7 Col. 6 Col. 7 Col. 6 Col. 6 Col. 7 Col. 6 Col. 6 Col. 7 Col. 7 Col. 6 Col. 7 Col. 6 Col. 7 Col. 6 Col. 7			0. 00					i i
12.	10. 00							10. 00
Amount Amount All owable In Cost Wkst. A, col. 5								
Allowable In Cost Wkst. A, col. 5) 4.00 5.00 6.00 PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 2.00 3.00 4.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 871,114 1,402,994 -531,880		12.	A	A +-	A -1: + + -			
Cost Wkst. A, col. col. 5)								
A.00 5.00 6.00								
A . 00 5 . 00 6 . 00			COST		(01.5)			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00			4 00		6.00			
CLAIMED HOME OFFICE COSTS:		PART I. COSTS INCURRED AND ADJUSTMENTS REQUIE				D ORGANIZATIONS	OR	
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 0 322, 994 -322, 994 -322, 994 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
3.00			871, 114					
4.00			0	322, 994	-322, 994			1
5.00 6.00 7.00 0 8.00 0 9.00 0 10.00 TOTALS (sum of lines 1-9). Transfer column 871,114 1,402,994 -531,880 5.00 6.00 7.00 8.00 9.00 10.00			0	0	0			
6.00 7.00 8.00 9.00 TOTALS (sum of lines 1-9). Transfer column 0 0 0 0 0 0 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 0 0 0 0 0 0 9.00 10.00			0	0	0			
7. 00 8. 00 9. 00 0 0 0 0 8. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0			1
8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column			0	0	0			1
9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 871,114 1,402,994 -531,880 9.00			0	0	0			
10.00 TOTALS (sum of lines 1-9). Transfer column 871,114 1,402,994 -531,880 10.00			0	0	0			
			0	0	0			1
	10.00	,	871, 114	1, 402, 994	-531, 880			10.00
		6, line 100 to Worksheet A-8, column 3, line						
		12.			l			I

3.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315525 Peri od: Worksheet A-8-1 From 01/01/2022 Parts I-II Date/Time Prepared: OFFICE COSTS 12/31/2022 6/1/2023 5: 35 pm Symbol (1) Name Percentage of Ownershi p

2.00

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.

1.00

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.

J				and the second s
1.00	A	ANNE-MARIE VAN DER VELDE	50.00	1. 00
2.00	A	MURPHY VAN DER VELDE	50.00	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:

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

- 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	Type of Business	1
		Ownershi p		
	4.00	5. 00	6. 00	
DART II INTERRE ATLANGUER TO BELATER ARABILT	ATTION (O) AND (OD HOME OFFI OF			

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

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

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

1.00		50.00	REALTY	1.00
2.00		50.00	REALTY	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
5	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.

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315525

Provider No.: 315525

Provider No.: 315525

Period:
From 01/01/2022
To 12/31/2022

Provider No.: 315525

Provider No.: 315525

Period:
From 01/01/2022
To 12/31/2022

Date/Time Prepared:
From 01/01/2022
Date/Time Pr

			CALLIAL KLL	AILD COSIS			
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
	oust defiter beschiptron	for Cost	FIXTURES	EQUI PMENT	BENEFITS	Subtotal	
		Allocation	TTATORES	Egott ment	DEILE TO		
		(from Wkst A					
		col . 7)					
		0	1.00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	1, 040, 461	1, 040, 461				1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	45, 000	1,010,101	45, 000			2. 00
3.00	00300 EMPLOYEE BENEFITS	878, 316	0	10, 000	878, 316		3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	767, 139	0	0	63, 991	831, 130	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	938, 780	0	0	51, 144	989, 924	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	5, 158	0	0	31, 144	5, 158	6. 00
7. 00	00700 HOUSEKEEPI NG	264, 536	o	0	38, 596	303, 132	7. 00
		1	0	0			
8.00	00800 DI ETARY	933, 401	0	0	109, 553	1, 042, 954	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	320, 913	0	0	60, 464	381, 377	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	147, 878	0	0	U O	147, 878	10.00
11. 00	01100 PHARMACY	74, 057	U	0	0	74, 057	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	40.005	0	0	0 (0)	0	12.00
	01300 SOCIAL SERVICE	49, 935	0	0	9, 626	59, 561	13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	179, 498	0	0	29, 244	208, 742	15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	2, 137, 630	302, 102	13, 066	388, 380	2, 841, 178	30. 00
	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 I CF/I I D	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	560, 658	738, 359	31, 934	108, 078	1, 439, 029	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	1, 820	0	0	0	1, 820	
41. 00	04100 LABORATORY	4, 751	0	0	0	4, 751	41.00
42.00	04200 I NTRAVENOUS THERAPY	463	0	0	0	463	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	86, 728	0	0	8, 176	94, 904	44.00
45.00	04500 OCCUPATI ONAL THERAPY	57, 128	0	0	9, 188	66, 316	45.00
46.00	04600 SPEECH PATHOLOGY	19, 450	0	0	1, 876	21, 326	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	O	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 196	0	0	0	19, 196	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	46, 644	O	0	0	46, 644	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	o	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	o	0	51.00
	OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
60.00	06000 CLI NI C	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	o	o	0	o	0	61. 00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS			<u>'</u>			
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	o	0	71. 00
73. 00	07300 CMHC	0	o	ō	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS	-1		-1	-1	-	
80 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 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	
89. 00	SUBTOTALS (sum of lines 1-84)	8, 579, 540	1, 040, 461	45, 000	878, 316	8, 579, 540	89. 00
07.00	NONREI MBURSABLE COST CENTERS	0, 377, 340	1,040,401	+3,000	070, 310	0, 377, 340	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	4, 361	0	0	٥	4, 361	
92. 00	09200 PHYSI CLANS PRI VATE OFFICES	4, 301	0	0	0	4, 301	92. 00
93. 00	09300 NONPAID WORKERS		0	0		0	93. 00
94.00	09400 PATI ENTS LAUNDRY		0	0		0	94. 00
98. 00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00	Negative Cost Centers		0	0	0	0	99. 00
100.00		8, 583, 901	1, 040, 461	45, 000	878, 316	8, 583, 901	
100.00	I I TOTAL	0, 505, 701	1, 040, 401	45,000	070, 310	0, 303, 701	100.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS HARBOUR VIEW SENIOR LIVING CENTER Provi der No.: 315525

				To	o 12/31/2022	Date/Time Pre 6/1/2023 5:35	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	DIII
	'	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	831, 130					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	106, 124	1, 096, 048	1			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	553	0		225 (22		6. 00
7.00	00700 HOUSEKEEPI NG	32, 497	0	0	335, 629	1 154 742	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	111, 809 40, 885	0		0	1, 154, 763 0	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	15, 853	0		0	0	10.00
11. 00	01100 PHARMACY	7, 939	0	Ö	0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	ō	0	0	12. 00
13.00	01300 SOCIAL SERVICE	6, 385	0	0	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	22, 378	0	0	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	204 500	040 040	0 444	07.454	/00 047	00.00
30. 00 31. 00		304, 588	318, 242		97, 451 0	629, 047 0	30. 00 31. 00
32.00	03200 CF/IID	0	0	1	0	0	32.00
33. 00		154, 270	777, 806	_	238, 178	525, 716	
00.00	ANCI LLARY SERVI CE COST CENTERS	101,270	777,000	2,000	200, 170	020,710	00.00
40.00	04000 RADI OLOGY	195	0	0	0	0	40. 00
41.00	04100 LABORATORY	509	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	50	0	0	0	0	42. 00
43.00		0	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	10, 174	0	0	0	0	44. 00
45. 00	· · · · · · · · · · · · · · · · · · ·	7, 109	0	0	0	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	2, 286	0		0	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 058	0		0	0	48. 00
49. 00	1 1	5, 000	0	ő	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	ō	0	0	50. 00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	1	0	0	1	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	O	0	0	0	0	61.00
62. 00	OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00		O	0	0	0	0	70. 00
71. 00	+ I	0	0	1	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00							80. 00
81. 00							81.00
82.00			0		0	0	82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	830, 662	0 1, 096, 048		335, 629	0 1, 154, 763	
67.00	NONREI MBURSABLE COST CENTERS	830, 002	1, 070, 040	5, 711	333, 024	1, 154, 703	09.00
90. 00		ol	0	0	0	0	90.00
91.00	The state of the s	468	0	o	0	0	
92.00	I I	0	0	0	O	0	•
93. 00		0	0	0	0	0	
94.00		0	0	0	0	0	94. 00
98.00	1	0	0	0	0	0	98. 00
99. 00 100. 00	1 1 0	831, 130	1 004 040	0 5, 711	225 420	1 154 762	99.00
100.00	D TOTAL	031, 130	1, 096, 048	ໆ ວ, / [[335, 629	1, 154, 763	1100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315525

| Period: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 6/1/2023 5:35 pm

						6/1/2023 5: 35	pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		9.00	10.00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS	7,00	10.00	11100	12.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	422, 262					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	163, 731				10.00
11.00	01100 PHARMACY	0	0	81, 996			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0		12.00
13.00	01300 SOCIAL SERVICE	0	0	0	0	65, 946	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	230, 023	89, 191	44, 667	0	35, 923	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	192, 239	74, 540	37, 329	0	30, 023	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	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	0	0	0	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	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 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)	422, 262	163, 731	81, 996	0	65, 946	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0		90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		92. 00
93. 00	09300 NONPALD WORKERS	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				98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	422, 262	163, 731	81, 996	0	65, 946	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315525 Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

					10 12/31/2022	6/1/2023 5: 35	pareu: nm
			OTHER GENERAL			07 17 2020 0.00	J
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
	· ·	ALLIED HEALTH			Adjustments		
		EDUCATI ON			,		
		14.00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 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						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	l				14. 00
15. 00	01500 ACTI VI TI ES	0	231, 120)			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	· ·	4, 719, 322		4, 719, 322	30. 00
31. 00	03100 NURSING FACILITY	0	0)	1 "	0	31.00
32. 00	03200 CF/IID	0	0		0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	105, 219	3, 576, 949	9 0	3, 576, 949	33. 00
	ANCILLARY SERVICE COST CENTERS	_			-1	0.045	
40.00	04000 RADI OLOGY	0		_, -,		2, 015	1
41. 00	04100 LABORATORY	0		5, 260		5, 260	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	513		513	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	105.076	-	105.070	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	105, 078		105, 078	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	73, 425		73, 425	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	23, 612		23, 612	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	1	-	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	21, 25 ⁴ 51, 64 ⁴		21, 254 51, 644	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		1		0	50.00
51. 00	05100 SUPPORT SURFACES	0	ŀ			0	51.00
31.00	OUTPATIENT SERVICE COST CENTERS	0	0	/	<u> </u>	0	31.00
60. 00	06000 CLINIC	0	0		0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	l	1		0	61.00
62. 00	06200 FQHC		Ĭ			Ŭ	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0) (0	0	70. 00
71. 00	07100 AMBULANCE	0	l .	1		0	71. 00
73. 00	07300 CMHC	0	l .		0		73. 00
	SPECIAL PURPOSE COST CENTERS						ĺ
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 HOSPI CE	0	0) (0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	231, 120	8, 579, 072	2 0	8, 579, 072	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0) (0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	4, 829	9 0	4, 829	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0) (0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0) (0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0) (0	0	94. 00
98. 00	Cross Foot Adjustments	0	0) (0	0	98. 00
99. 00	Negative Cost Centers	0) (0	0	99. 00
100.00) TOTAL	0	231, 120	8, 583, 901	1 0	8, 583, 901	100. 00

In Lieu of Form CMS-2540-10

| Period: | Worksheet B |
| From 01/01/2022 | Part II |
| To 12/31/2022 | Date/Time Prepared: 6/1/2023 5:35 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315525

					12/31/2022	6/1/2023 5: 35	
			CAPI TAL REI	LATED COSTS			
		D	DI DOC. A	HOVADIE		EMPL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal	TIATURES	LQUIFWLINI		DLINLITIS	
		Related Costs					
		0	1.00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0		0	0	2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	0	0	0	0	0	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS		0	0	0	0	5.00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7. 00	00700 HOUSEKEEPI NG	o	0	O	0	0	7. 00
8.00	00800 DI ETARY	0	0	0	0	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	13. 00 14. 00
15. 00	01500 ACTIVITIES		0	0	0	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			<u> </u>	0	13.00
30. 00	03000 SKILLED NURSING FACILITY	0	302, 102	13, 066	315, 168	0	30. 00
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
32. 00	03200 I CF/I I D	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	738, 359	31, 934	770, 293	0	33. 00
	ANCILLARY SERVICE COST CENTERS			1	al		
40.00	04000 RADI OLOGY	0	0		0	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY		0	0	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	o	0	O	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 OUTPATIENT SERVICE COST CENTERS	<u> </u>		0	U	0	51.00
60. 00	06000 CLINIC	O	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	o	0		Ö	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
90 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			80.00
81.00	08100 NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 H0SPI CE	o	0	0	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 040, 461	45, 000	1, 085, 461	0	1
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	1
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0	0	0	0	93. 00 94. 00
98. 00	Cross Foot Adjustments	١	Ü		0	0	98.00
99. 00	Negative Cost Centers		Ω	0	n	0	
100.00		0	1, 040, 461	45, 000	1, 085, 461		100.00
	•	1					•

| Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315525

				Т	o 12/31/2022	Date/Time Pre 6/1/2023 5:35	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Pili
	'	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00	00300 EMPLOYEE BENEFITS	_					3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0					4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE		(0			5. 00 6. 00
7. 00	00700 HOUSEKEEPING	0		0	0		7.00
8.00	00800 DI ETARY	0	C	0	0	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	C	0	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	C	0	0	0	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	C	0	0	0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	0		0	0	0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	O	C	ő	0	-	14. 00
15.00	01500 ACTI VI TI ES	0	C	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00	03000 SKILLED NURSING FACILITY	0	C				30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	C				31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	C		_	_	33.00
00.00	ANCI LLARY SERVI CE COST CENTERS	9					00.00
40.00	04000 RADI OLOGY	0	C	0	0	0	40. 00
41. 00	04100 LABORATORY	0	C	_	0	-	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	C	0	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	(0	0	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0		Ö	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	C	Ō	0	0	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	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES		C	0	0	0 0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		· · · · · · · · ·	J		31.00
60.00	06000 CLI NI C	0	C	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	C	0	0	0	61. 00
62. 00	06200 FOHC						62.00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	C	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	C	l .			71.00
	07300 CMHC	0	C		_		73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	0	C	О	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	0	C	l .			1
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C				
91. 00		0	C	0	0		
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	C	0	0	0	
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		(0	0	0 0	1
98. 00	Cross Foot Adjustments				0	0	
99. 00	Negative Cost Centers	0	C	Ō	0	0	99. 00
100.00	TOTAL	0	C	0	0	0	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315525

In Lieu of Form CMS-2540-10

| Period: | Worksheet B |
| From 01/01/2022 | Part II |
| To 12/31/2022 | Date/Time Prepared: 6/1/2023 5:35 pm

				12/31/2022	6/1/2023 5: 35	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	9.00	10. 00	11. 00	12.00	13. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00 00300 EMPLOYEE BENEFITS						3. 00
4.00 00400 ADMINISTRATIVE & GENERAL						4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00 00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 00700 HOUSEKEEPI NG						7. 00
8. 00 00800 DI ETARY						8. 00
9. 00 00900 NURSING ADMINISTRATION	0					9. 00
10. 00 01000 CENTRAL SERVI CES & SUPPLY	0	0				10.00
11. 00 01100 PHARMACY	0	0	0			11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY		0	0	0		12. 00
13. 00 01300 SOCI AL SERVI CE		0	0	0	0	13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION		0	0	0	0	14. 00
15. 00 01500 ACTIVITIES		0	0	0		15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	l d	U _I	U _l	0		15.00
30. 00 03000 SKILLED NURSING FACILITY	l ol	0	0		0	30.00
31. 00 03100 NURSI NG FACILITY		0	0	0	•	31.00
		0	-			
32. 00 03200 1CF/IID	1	0	0	0		32.00
33. 00 O3300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS		ما				40.00
40. 00 04000 RADI OLOGY	0	0	0	0		40.00
41. 00 04100 LABORATORY	0	0	0	0	1	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 O4400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00 O4600 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	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	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 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00 07100 AMBULANCE	o	o	0	0	0	71. 00
73. 00 07300 CMHC	o	0	0	0	0	73. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100 INTEREST EXPENSE						81. 00
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83. 00 08300 H0SPI CE	0	0	0	0	0	
89.00 SUBTOTALS (sum of lines 1-84)	o	o	Ō	0		•
NONREI MBURSABLE COST CENTERS	-1			-		
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	o	0	0	0	-	91. 00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES		o o	0	0	Ö	92.00
93. 00 09300 NONPALD WORKERS		0	0	0	0	93.00
94. 00 09400 PATI ENTS LAUNDRY			0	0	0	94. 00
98.00 Cross Foot Adjustments		0	0	Ü		98.00
99.00 Negative Cost Centers		0	0	0	0	99.00
100.00 TOTAL		0	0	0		100.00
100.00 101AL	١	٥Į	υ	O	1	1100.00

ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315525 Peri od: Worksheet B From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 6/1/2023 5: 35 pm OTHER GENERAL SERVI CE Cost Center Description NURSING AND ACTI VI TI ES Subtotal Post Step-Down Total ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 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 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 ACTI VI TI ES 15.00 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 0 315, 168 0 315, 168 30.00 31.00 03100 NURSING FACILITY 0 0 0 0 31.00 03200 | CF/IID 0 32.00 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 770, 293 0 770, 293 33.00 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 0 0 41.00 04100 LABORATORY 0000000000 0 0 0 0 0 0 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 0 0 45.00 0 45.00 04600 SPEECH PATHOLOGY 0 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 48 00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 50.00 C 0 51.00 05100 SUPPORT SURFACES 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 60.00 0 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 0 61.00 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 73.00 07300 CMHC 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 08300 H0SPI CE 83 00 83.00 0 Λ SUBTOTALS (sum of lines 1-84) 89.00 0 0 1, 085, 461 1, 085, 461 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 00000 0 0 0 0 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 91.00

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1, 085, 461

0 92.00

0 93.00

0 98.00

0 99.00

1, 085, 461 100. 00

94.00 0

92.00

93.00

94.00

98.00

99. 00

100.00

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

09300 NONPALD WORKERS

TOTAL

09400 PATIENTS LAUNDRY

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315525

				Т	o 12/31/2022	Date/Time Pre 6/1/2023 5:35	
		CAPITAL RE	LATED COSTS			07172023 5.33	Pill
	Cost Center Description	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
		1.00	2.00	SALARI ES) 3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	77, 595					1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	77, 595 0	4, 556, 292			2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	0	0	331, 957		7, 752, 771	1
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0	265, 313		707, 721	1
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	0	0	0 200, 217	_	5, 158 303, 132	
8.00	00800 DI ETARY		0	568, 311		1, 042, 954	1
9. 00	00900 NURSING ADMINISTRATION	0	0	313, 660	C	381, 377	1
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	C	147, 878	
11. 00 12. 00	O1100 PHARMACY O1200 MEDI CAL RECORDS & LI BRARY	0	0	0		74, 057 0	1
13. 00	01300 SOCIAL SERVICE		0	49, 935		59, 561	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	C	0	14. 00
15. 00	01500 ACTIVITIES	0	0	151, 706	C	208, 742	15. 00
30. 00	I NPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	22, 530	22, 530	2, 014, 729	C	2, 841, 178	30.00
31. 00	03100 NURSING FACILITY	0	0	2,014,727			1
32. 00	03200 CF/IID	0	0	0	C	1	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	55, 065	55, 065	560, 658	C	1, 439, 029	33. 00
40. 00	04000 RADIOLOGY		0	0) .	1, 820	40.00
41. 00	04100 LABORATORY	0		Ö	C	4, 751	
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	C	463	1
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	0 42, 412		0 94, 904	
45. 00	04500 OCCUPATI ONAL THERAPY		0	47, 663		66, 316	1
46.00	04600 SPEECH PATHOLOGY	0	0	9, 731		21, 326	
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	C	0	
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0			19, 196 46, 644	
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	Ö	Ö	o c	1	1
51.00	05100 SUPPORT SURFACES	0	0	0	C	0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS O6000 CLINIC		O	0		0	40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC				_		
62. 00	06200 FQHC			_			62. 00
70.00	OTHER REIMBURSABLE COST CENTERS	1	1				
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0					
73. 00	07300 CMHC				_	1	1
	SPECIAL PURPOSE COST CENTERS	i	1		1		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00
81. 00 82. 00	08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	08300 H0SPI CE	0	О	0	C	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	77, 595	77, 595	4, 556, 292	-831, 130	7, 748, 410	89. 00
90. 00	NONREI MBURSABLE COST CENTERS O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	T 0	O	0) C	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP				_		1
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	C	0	
93. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0	0	C	0	
94. 00 98. 00	Cross Foot Adjustments		0	0		,	94. 00 98. 00
99. 00	Negative Cost Centers						99. 00
102.00		1, 040, 461	45, 000	878, 316	•	831, 130	102. 00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	13. 408867	0. 579934	0. 192770		0. 107204	103 00
103.00		13. 400007	0. 377734	0. 172770		l .	103.00
	Part II)						
105.00	Unit cost multiplier (Wkst. B, Part			0. 000000	1	0.000000	105. 00
	1 1117	I	1	I	T	I	I

Coat Center Description							o 12/31/2022	Date/Time Pre 6/1/2023 5:35	
MAINT 8 SPENDING COST CENTERS SOME FEET) SOME FEE			Cost Center Description					NURSI NG	piii
				•		(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
CAN INDEX STRAYCE COST CHITISS					(TATTENT DATS)			(PATIENT DAYS)	
ENNINAL SERVICE COST CENTERS 1					/ 00	7.00	0.00	0.00	
1.00		GENER	AL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
3.00		00100	CAP REL COSTS - BLDGS & FIXTURES						
4.00 0.000 ADMINISTRATIVE & GENERAL 5.00 0.000 0.00000 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0		1							
0.0000 PLANT OFFENTION, MAINT: & REPAIRS 77, 995		1							
7. 00 00700 MUSES KER ADMINI STRATION 0 0 0 77, 595 111, 609 8.00 0 0.00 CHIRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 110, 00 0 0 0 0 0 1 0 0 0 0		1		77, 595					
0.000 0.0000 DIETARY 0				0	1				
9.00 0.0900 NURSI NO ADMINISTRATION 0 0 0 0 0 0 0 0 0						77, 595			
1.1 0.0 10.00 PHARMARCY 0 0 0 0 0 1.1 0.00	9.00	1		0	0	0	0	37, 203	
12 00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 13. 00 130 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 14. 00 0 0 0 0 0 0 0 0 0		1		0	0	0	0		
13.00 01300 SOCIAL SERVICE 0 0 0 0 0 0 114.00		1	l e e e e e e e e e e e e e e e e e e e			0	0	_	
15.00 01500 ACTIVITIES 0 0 0 0 0 0 0 0 0		01300	SOCIAL SERVICE	0	0	0	0	0	
IMPATI ENT ROUTINE SERVICE COST CENTERS				0	0	0	0	_	
30.00 03000 SKILLED NURSING FACILITY	13.00		I .	0		<u> </u>	U	0	15.00
32.00 03200 CFF I D NG TERN CARE		03000	SKILLED NURSING FACILITY	22, 530	20, 266	22, 530	60, 798	20, 266	•
33.00		1	ł	0	1		0	-	
40.00 0-0000 0-000 0-00 0 0 0				55, 065	1	· -	50, 811	_	
11 00 04100 LABORATORY 0				1		1			
A2 00 04200 INITAXYENOUS THERAPY				0	1		0	-	
44. 00		1		0	Ö	Ö	0	-	
45. 00 04500 04500 04500 0500 04500 0 0 0 0 0 0 0 0 0		1	, ,	0	0	0	0	-	
46.00 04600 SPECH PATHOLOGY 0 0 0 0 0 0 0 46.00 47.00 04700 ELCTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 49.00 04900 DURISC CHARGED TO PATIENTS 0 0 0 0 0 0 0 51.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51.00 05000 DURISC CHARGED TO PATIENTS 0 0 0 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 60.00 05000 05000 0 0 0 0 0		1		0	0	0	0	-	
48. 00 04900 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 48. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 00 00 0 0	46.00	1		Ö	ő	Ö	0	_	
49.00 04900 DAVIGIS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1		0	0	0	0	_	
SO.00 OSO00 DENTAL CARE - TITLE XIX ONLY O O O O O O O O O				0	0		0	_	
OUTPATE ENT SERVICE COST CENTERS O				0	Ö	Ö	0		
60.00	51. 00			0	0	0	0	0	51. 00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 62.00	60. 00			T 0	0	0		0	60.00
OTHER REIMBURSABLE COST CENTERS O		06100	RURAL HEALTH CLINIC	0	0	0	0	0	
70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 71. 00 71. 00 0700 AMBULANCE 0 0 0 0 0 0 0 0 0	62. 00								62. 00
73.00 73.00 CMHC SPECIAL PURPOSE COST CENTERS	70. 00			0	0	0	0	0	70. 00
SPECIAL PURPOSE COST CENTERS 80.00 MALPRACTI CE PREMI UNS & PAI D LOSSES 81.00 81.00 81.00 81.00 81.00 81.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 83.00		1		0				_	
80. 00	73. 00			0	0	0	0	0	73. 00
82. 00	80.00								80. 00
83.00 08300 HOSPICE 0 0 0 0 0 0 83.00 89.00		1							
89.00 SUBTOTALS (sum of lines 1-84) 77,595 37,203 77,595 111,609 37,203 89.00				0	0	0	0	0	
90. 00		00000		1	-		111, 609	_	
91.00	00.00			1 0	1 0	1 0			00.00
92. 00				0	1				
94. 00	92.00	09200	PHYSICIANS PRIVATE OFFICES	0	Ō	0	0	_	92. 00
98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) 14.125240 0.153509 4.325395 10.346504 11.350214 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.000				0	0	0	0	_	
99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, Part I) 14.125240 0.153509 4.325395 10.346504 11.350214 103.00 Unit cost multiplier (Wkst. B, Part I) 14.125240 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000		09400		0	0	0	U	Ü	•
Part I) 103.00 104.00 105.00 107.00 108.00 Part II) 108.00 Part II) 109.00 Part II) 1008.00 Part II) 1009.00 Part II) Part III) Part III) Part III) Part III) Part III	99. 00		Negative Cost Centers						99. 00
103.00 Unit cost multiplier (Wkst. B, Part I) 14.125240 0.153509 4.325395 10.346504 11.350214 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 0 0 0 0 0 0 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	102.00			1, 096, 048	5, 711	335, 629	1, 154, 763	422, 262	102. 00
104.00 Cost to be allocated (per Wkst. B, Part 0.0000000 0.00000000	103.00		l ,	14. 125240	0. 153509	4. 325395	10. 346504	11. 350214	103. 00
105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 0.000000			Cost to be allocated (per Wkst. B,	0	0	0	0		
	105 00			0 000000	0 000000	0 000000	0 000000	0 000000	105, 00
			. ,						

Provi der No.: 315525

Peri od:

From 01/01/2022

12/31/2022 Date/Time Prepared: 6/1/2023 5: 35 pm Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND RECORDS & SERVICES & (PATIENT DAYS) ALLI ED HEALTH **SUPPLY** LI BRARY (PATIENT DAYS) **EDUCATION** (ASSI GNED (PATIENT DAYS) (PATLENT DAYS) TIME) 12.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 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 37, 203 10.00 11.00 01100 PHARMACY 37, 203 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 37, 203 12.00 01300 SOCIAL SERVICE 37, 203 13 00 0 13 00 C C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 20, 266 20, 266 20, 266 20, 266 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 32.00 03300 OTHER LONG TERM CARE 16, 937 16, <u>9</u>37 33.00 16, 937 16, 937 0 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 C 41.00 04100 LABORATORY 0 0 0 0 41.00 0000000000 04200 I NTRAVENOUS THERAPY 0 42 00 42 00 Ω 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 0 0 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 r 0 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 61.00 0 Ω 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 0 83.00 SUBTOTALS (sum of lines 1-84) 89.00 37, 203 37, 203 37, 203 37, 203 0 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP C 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 0 93.00 09300 NONPALD WORKERS 0 0 93.00 94 00 09400 PATIENTS LAUNDRY 0 O ol 94 00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 81, 996 65, 946 0 102.00 102.00 163, 731 Part I) 0.000000 103.00 103 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 4. 401016 2. 204016 1.772599 104.00 Cost to be allocated (per Wkst. B, 0 104.00 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 11)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10 Provi der No.: 315525

				10 12/31/2022 Date/II me Prep 6/1/2023 5: 35	
			OTHER GENERAL	07 17 2020 0.00	Pill
			SERVI CE		
		Cost Center Description	ACTI VI TI ES		
		·	(PATIENT DAYS)		
			15. 00		
		AL SERVICE COST CENTERS			
1.00	1	CAP REL COSTS - BLDGS & FIXTURES			1. 00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	1	EMPLOYEE BENEFITS			3. 00
4.00		ADMINISTRATIVE & GENERAL			4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	1	LAUNDRY & LINEN SERVICE			6. 00
7.00	1	HOUSEKEEPING			7. 00
8.00		DIETARY			8. 00
9.00		NURSI NG ADMI NI STRATI ON			9. 00
10.00		CENTRAL SERVICES & SUPPLY			10.00
11.00	1	PHARMACY			11.00
12.00	1	MEDICAL RECORDS & LIBRARY			12.00
13.00	1	SOCIAL SERVICE			13.00
14. 00 15. 00	1	NURSING AND ALLIED HEALTH EDUCATION	27 202		14. 00 15. 00
13.00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	37, 203		13.00
30. 00		SKILLED NURSING FACILITY	20, 266		30. 00
31. 00	1	NURSING FACILITY	20, 200		31. 00
32. 00	1	ICF/IID	0		32. 00
33. 00	1	OTHER LONG TERM CARE	16, 937		33. 00
		LARY SERVICE COST CENTERS			
40.00	04000	RADI OLOGY	0		40. 00
41.00	04100	LABORATORY	0		41.00
42.00	04200	INTRAVENOUS THERAPY	0		42.00
43.00	1	OXYGEN (INHALATION) THERAPY	0		43.00
44. 00	1	PHYSI CAL THERAPY	0		44. 00
45. 00	1	OCCUPATI ONAL THERAPY	0		45. 00
46. 00	1	SPEECH PATHOLOGY	0		46. 00
47. 00		ELECTROCARDI OLOGY	0		47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS	0		49. 00 50. 00
51.00	1	DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0		51. 00
31.00		TIENT SERVICE COST CENTERS	0		31.00
60.00		CLINIC	0		60. 00
61. 00	1	RURAL HEALTH CLINIC	o		61. 00
62.00	06200				62.00
	OTHER	REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	0		70.00
71. 00	1	AMBULANCE	0		71. 00
73. 00	07300		0		73. 00
00.00		AL PURPOSE COST CENTERS			00.00
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES			80.00
		INTEREST EXPENSE			81. 00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0		82. 00 83. 00
89. 00	00300	SUBTOTALS (sum of lines 1-84)	37, 203		89. 00
07.00	NONRE	IMBURSABLE COST CENTERS	37, 203		09.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90. 00
91. 00	1	BARBER AND BEAUTY SHOP	0		91. 00
92. 00		PHYSICIANS PRIVATE OFFICES	O		92. 00
93.00		NONPALD WORKERS	O		93. 00
94. 00	1	PATIENTS LAUNDRY	o		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,	231, 120		102. 00
		Part I)			
103.00	1	Unit cost multiplier (Wkst. B, Part I)	6. 212402		103. 00
104.00	ן	Cost to be allocated (per Wkst. B,	0		104. 00
105.00		Part II)	0.000000		105 00
105. 00	ľ	Unit cost multiplier (Wkst. B, Part II)	0. 000000		105. 00
	I	1''7	ı	· · · · · · · · · · · · · · · · · · ·	

62. 00 06200 FQHC

100.00

71. 00 07100 AMBULANCE

Total

62.00

71.00

100.00

0. 000000

0

320, 027

282, 801

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315525 Peri od: Worksheet C From 01/01/2022 To 12/31/2022 Date/Time Prepared: 6/1/2023 5:35 pm Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col . 2 col . 18 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 2, 015 6, 625 0. 304151 40.00 41. 00 | 04100 | LABORATORY 5, 260 4, 751 1.107135 41.00 1. 107991 42. 00 04200 I NTRAVENOUS THERAPY 513 463 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 105, 078 115, 946 0. 906267 44.00 45. 00 04500 OCCUPATIONAL THERAPY 73, 425 109, 172 0.672563 45.00 46.00 04600 SPEECH PATHOLOGY 17, 230 1. 370400 23, 612 46.00 47. 00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 21, 254 19, 196 1.107210 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 1. 107195 49.00 51, 644 46, 644 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 0 51.00 05100 SUPPORT SURFACES 0 0.000000 51.00 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0.000000 60.00 60.00 0 0 61.00 06100 RURAL HEALTH CLINIC 61.00

Heal th	Financial Systems HA	RBOUR VIEW SENI	OR LIVING CENTE	ER	In Li∈	eu of Form CMS-	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315525	Peri od: From 01/01/2022 To 12/31/2022		
				XVIII (1)	Skilled Nursing Facility		
			Health Care Pr	rogram Charge	es Health Care	Program Cost	
		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - CALCULATION OF ANCILLARY AND OUTPA	FLENT COST					
	ANCILLARY SERVICE COST CENTERS						_
40. 00	04000 RADI 0L0GY	0. 304151			0 2, 015		
41. 00	04100 LABORATORY	1. 107135			0 5, 260		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	1. 107991	l e		0 513	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0. 906267			0 99, 989		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0. 672563			0 73, 425		1 .0.00
46. 00	04600 SPEECH PATHOLOGY	1. 370400			0 5, 383	0	1 .0.00
47. 00	04700 ELECTROCARDI OLOGY	0. 000000	l .		0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 107210			0 21, 254	0	1 .0.00
	04900 DRUGS CHARGED TO PATIENTS	1. 107195			0 26, 753	0	1
	05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	l		0		50.00
51.00	05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0.000000		I		0	1,0,00
		0. 000000	0		0 0	0	
	06100 RURAL HEALTH CLINIC 06200 FOHC						61. 00 62. 00
	07100 AMBULANCE (2)	0.000000					71. 00
100.00		0. 000000	l e		0 234, 592		100.00
	t to the second		278, 629	I	0 234, 592	ı	1100.00
(1) FO	r title V and XIX use columns 1, 2, and 4 on	ı y.					

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

Heal th	Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10								
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315525	Period: From 01/01/2022 To 12/31/2022				
			Ti tl	e XVIII	Skilled Nursing Facility	PPS			
	Cost Center Description								
	PART II - APPORTIONMENT OF VACCINE COST					1. 00			
1. 00	Drugs charged to patients - ratio of co	et to charges	(Erom Workshoo	t C column 2	Lino 40)	1. 107195	1.00		
2.00	Program vaccine charges (From your reco			t C, Corumin 3,	11116 47)	1. 10/143	1		
3. 00	Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	Ö			
	E, Part I, line 18)	,							
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A				
			Allied Health		Cost (From	& Allied			
			(From Wkst. B,			Health Costs			
		18		Costs to Tota		for Pass			
			14)	Costs - Part (Col. 2 / Col		Through (Col. 3 x Col. 4)			
				1)	•	3 X COI. 4)			
		1.00	2.00	3.00	4. 00	5. 00			
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH	•					
	ANCILLARY SERVICE COST CENTERS								
	04000 RADI OLOGY	2, 015				0			
41. 00	04100 LABORATORY	5, 260		0. 00000					
42.00	04200 NTRAVENOUS THERAPY	513	0	0.00000		0			
43.00	04300 OXYGEN (INHALATION) THERAPY	105.070	0	0.00000		0			
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	105, 078 73, 425	l e	0. 00000 0. 00000		0			
46. 00	04500 SPEECH PATHOLOGY	73, 425 23, 612	l e	0.00000		0			
47. 00	04700 ELECTROCARDI OLOGY	23,012		0.00000		0			
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 254		0. 00000		0			
49. 00	04900 DRUGS CHARGED TO PATIENTS	51, 644	l e	0. 00000		Ö			
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		0.00000		0	1		
51.00	05100 SUPPORT SURFACES	0	0	0.00000		0	51.00		
100.00	Total (Sum of lines 40 - 52)	282, 801	0		234, 592	0	100. 00		

Heal th	Financial Systems HARBOUR VIEW SENIOR	LIVING CENTER	In Lie	u of Form CMS-2	2540-10	
COMPUT	TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315525	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 6/1/2023 5:35	pared:	
		Title XVIII	Skilled Nursing Facility	PPS		
				1. 00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS					
	I NPATI ENT DAYS					
1.00	Inpatient days including private room days			20, 266		
2.00	Private room days	Dunganom		0		
3. 00 4. 00	Inpatient days including private room days applicable to the I Medically necessary private room days applicable to the Progra			2, 611 0	1	
5.00	Total general inpatient routine service cost	alli		4, 719, 322		
5.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			4, 717, 322	3.00	
6.00	General inpatient routine service charges			6, 647, 012	6.00	
7.00	General inpatient routine service cost/charge ratio (Line 5 d	divided by line 6)		0. 709991	7. 00	
8.00	Enter private room charges from your records			0	8. 00	
9. 00	Average private room per diem charge (Private room charges li	ne 8 divided by private	room days, line	0.00	9. 00	
10.00	Enter semi-private room charges from your records			0	10.00	
11. 00	00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by					
	semi-private room days)				12. 00	
12. 00						
13.00						
14. 00 15. 00	· · · · · · · · · · · · · · · · · · ·					
13.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	st differential (Eine 5	III Tius TTTIE 14)	4, 719, 322	15. 00	
16. 00	Adjusted general inpatient service cost per diem (Line 15 diem	vided by line 1)		232. 87	16.00	
17.00	Program routine service cost (Line 3 times line 16)	,		608, 024	1	
18.00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18. 00	
19. 00	Total program general inpatient routine service cost (Line 1			608, 024		
20. 00	Capital related cost allocated to inpatient routine service of line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From Wkst. B, Par	t II column 18,	315, 168	20.00	
21. 00				15. 55	21.00	
22. 00	,			40, 601		
	Inpatient routine service cost (Line 19 minus line 22)			567, 423		
24.00	Aggregate charges to beneficiaries for excess costs (From pro	ovi der records)		0	24. 00	
25.00	Total program routine service costs for comparison to the cos	t limitation (Line 23 mi	nus line 24)	567, 423	25. 00	
26. 00					26. 00	
	Inpatient routine service cost limitation (Line 3 times the pe				27. 00	
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the Cost of the Manual Cost of the Cost of	he lesser of line 25 or	line 27)		28. 00	
(1) Li	(Transfer to Worksheet E, Part II, line 4) (See instructions) nes 26 and 27 are not applicable for title XVIII, but may be us	sed for title V and or t	itle XIX		I	
				1. 00		
1 00	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	S FOR PPS PASS-THROUGH		20.244	1 00	
1. 00 2. 00	Total SNF inpatient days Program inpatient days (see instructions)			20, 266 2, 611	1	
3.00	Total nursing & allied health costs. (see instructions) (Do no:	t complete for titles V	or XLX)	2,611	1	
4.00		Complete for titles V	OI AIA)			
	0 Nursing & allied health ratio. (line 2 divided by line 1) 0.128836 4. 0 Program nursing & allied health costs for pass-through. (line 3 times line 4) 0 5.					

MCRI	F32	_	10	12	175	6

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315525	Peri od: From 01/01/2022	Worksheet D-1 Parts I-II	
			To 12/31/2022	Date/Time Prep 6/1/2023 5:35	
		Title XIX	Skilled Nursing Facility	Cost	рш
			Taciffty	1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			20, 266	
. 00	Private room days			0	2.0
3. 00	Inpatient days including private room days applicable to the F			11, 416	
l. 00 5. 00	Medically necessary private room days applicable to the Progra Total general inpatient routine service cost	ım		0 4, 719, 322	
3. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			4, /19, 322	3.0
5. 00	General inpatient routine service charges			6, 647, 012	6.0
7.00	General inpatient routine service cost/charge ratio (Line 5 c	divided by line 6)		0. 709991	
3. 00	Enter private room charges from your records	ý		0	8.0
0.00	Average private room per diem charge (Private room charges lir 2)	ne 8 divided by private	room days, line	0.00	
0.00	Enter semi-private room charges from your records	0			
1. 00	Average semi-private room per diem charge (Semi-private room semi-private room days)	0.00	11. C		
2. 00					
3. 00					
14.00	00 Private room cost differential adjustment (Line 2 times line 13) 00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)				
5.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	st differential (Line 5	minus iine 14)	4, 719, 322	15.0
6. 00	Adjusted general inpatient service cost per diem (Line 15 div	/ided by line 1)		232. 87	16. C
7. 00	Program routine service cost (Line 3 times line 16)			2, 658, 444	
8. 00				0	
9. 00	Total program general inpatient routine service cost (Line 17		10	2, 658, 444	•
0. 00	Capital related cost allocated to inpatient routine service colline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From WKSt. B, Par	T II COLUMN 18,	315, 168	
1.00	, , , , , , , , , , , , , , , , , , , ,			15. 55	
2.00	Program capital related cost (Line 3 times line 21)			177, 519	
	Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From pro	wider records)		2, 480, 925 0	
25. 00			nus Line 24)	2, 480, 925	
26. 00		, Trim tatron (Erne 25 iii	nus iine z+)	0.00	
	Inpatient routine service cost limitation (Line 3 times the pe	er diem limitation line	26) (1)	0	
	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)			2, 658, 444	28. 0
1) Li	nes 26 and 27 are not applicable for title XVIII, but may be us	sed for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH			
. 00	Total SNF inpatient days			20, 266	1.0
. 00	Program inpatient days (see instructions)			11, 416	
3. 00	Total nursing & allied health costs. (see instructions)(Do not	complete for titles V	or XIX)	0	
4.00	Nursing & allied health ratio. (line 2 divided by line 1)			0. 563308	
5. 00	Program nursing & allied health costs for pass-through. (line	3 times line 4)		0	5.0

Health Financial Systems	HARBOUR	VIEW SENIOR LI	VING CENTER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT	SETTLEMENT FOR TITLE XVIII		Provi der No.: 315525	From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Prepared: 6/1/2023 5:35 pm
			Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
		1. 00			
1. 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSI Inpatient PPS amount (See Instructions)	EMENI		1, 953, 828	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	vmonts)		1, 955, 626	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	ymerits)		1, 953, 828	3. 00
4.00	Primary payor amounts			1, 455, 626	4. 00
5.00	Coinsurance			304, 587	5. 00
6.00	Allowable bad debts (From your records)			0	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)	Ct1 0113)		0	
9. 00	Recovery of bad debts - for statistical records only			0	
10. 00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			1, 649, 241	
12. 00	Interim payments (See instructions)			1, 625, 109	
13. 00	Tentative adjustment			1, 023, 107	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. 75	Seguestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			24, 132	
15. 00	Balance due provider/program (see Instructions)			0	
16. 00					
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER				
17.00	Ancillary services Part B			0	17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00
22. 00	Primary payor amounts			0	22. 00
23.00	Coinsurance and deductibles			0	23. 00
24.00	Allowable bad debts (From your records)			0	24.00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00					26. 00
27. 00	10 Tentati ve adjustment				27. 00
28. 00	, , ,				28. 00
28. 50					28. 50
28. 55					28. 55
28. 99	Sequestration amount (see instructions)			0	
29. 00	Balance due provider/program (see instructions)			0	
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section 115.2	0	30. 00

Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER			In Lieu of Form CMS-2540-10			
CALCULATION OF REIMBURSEMENT SETTLE	MENT TITLE V and TITLE XIX ONLY	Provi der No.: 315525	Period: Worksheet E From 01/01/2022 Part II To 12/31/2022 Date/Time Pr 6/1/2023 5:3			
		Title XIX	Skilled Nursing Facility	Cost	•	

	Facility		
		1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		
1.00	Inpatient ancillary services (see Instructions)	0	1. 00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)	0	2. 00
3.00	Outpatient services	0	3.00
4.00	Inpatient routine services (see instructions)	2, 658, 444	4. 00
5.00	Utilization reviewphysicians' compensation (from provider records)	0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)	2, 658, 444	6.00
7.00	Differential in charges between semiprivate accommodations and less than semiprivate accommodations	0	7. 00
8.00	SUBTOTAL (Line 6 minus line 7)	2, 658, 444	8. 00
9.00	Primary payor amounts	0	9. 00
10.00	Total Reasonable Cost (Line 8 minus line 9)	2, 658, 444	10.00
	REASONABLE CHARGES		
11.00	Inpatient ancillary service charges	0	11.00
12.00	Outpatient service charges	0	12.00
13.00	Inpatient routine service charges	0	13.00
14.00	Differential in charges between semiprivate accommodations and less than semiprivate accommodations	o	14.00
15.00	Total reasonable charges	o	15.00
	CUSTOMARY CHARGES		
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	17.00
	had such payment been made in accordance with 42 CFR 413.13(e)		
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)	0.000000	
19. 00	Total customary charges (see instructions)	0	19.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
20.00	Cost of covered services (see Instructions)	0	20.00
21.00	Deducti bl es	0	21.00
22. 00	Subtotal (Line 20 minus line 21)	0	22.00
23.00	Coi nsurance	0	23.00
24.00	Subtotal (Line 22 minus line 23)	0	24.00
25.00	Allowable bad debts (from your records)	0	25.00
26.00	Subtotal (sum of lines 24 and 25)	0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of	0	27.00
	cost limit		
28. 00	Recovery of excess depreciation resulting from provider termination or a decrease in program	0	28. 00
	uti l i zati on		
29. 00	Other Adjustments (see instructions) Specify	0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (0	30.00
	if minus, enter amount in parentheses)		
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)	0	31.00
32.00	Interim payments	0	32.00
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	0	33.00
	Instructions)		

HARBOUR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2540-10 Provi der No.: 315525 Peri od: Worksheet E-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 6/1/2023 5:35 pm Title XVIII Skilled Nursing PPS

Inpatient Part A			11 (1	e AVIII	Facility	PPS	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A		rt B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm /dd /\n\n\	Amount	mm /dd /\nnn/	Amount	
Total interim payments paid to provider							
InterIm payments payable on Individual Bills, either submitted or to be submitted for the cost reporting period. If none, enter zero 3.00	1. 00	Total interim payments paid to provider	1.00		0.00		1.00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero				0			
Online Contractor Online							
1. 1. 1. 1. 1. 1. 1. 1.		services rendered in the cost reporting period. If none,					
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)		1					
For the cost reporting period. Also show date of each payments. If none, write "NONE" or enter a zero. (1) Program to Provider	3. 00						3. 00
payment, If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							-
3.02 3.03 3.04 3.05 3.07	2 01			0		1 0	2 01
3. 03 0.0 0.		ADJUSTIVIENTS TO PROVIDER				1	
3. 04 0						1	
3.05						1	
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3 , 50 3 , 50 0 0 3 , 50 3 , 50 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 3 , 50 0 0 0 3 , 50 0 0 0 3 , 50 0 0 0 3 , 50 0 0 0 3 , 50 0 0 0 3 , 50 0 0 0 0 0 0 0 0 0				-			
ADJUSTMENTS TO PROGRAM	0.00	Provider to Program		<u> </u>			0.00
3.52 3.53 3.54 3.99 3.53 3.54 3.99 3.53 3.54 3.99 3.98 3.54 3.99 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55 3.98 3.55	3.50			0		0	3. 50
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 0 3.54 3.99 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,625,109 0 4.00	3.51			0		0	3. 51
3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.54	3.52			0		0	3. 52
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.99 -3.98	3.53			0		0	3. 53
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)				0		0	
A 00	3. 99			0		0	3. 99
Circansfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR							
26 for Part B) TO BE COMPLETED BY CONTRACTOR	4.00			1, 625, 109		0	4.00
TO BE COMPLETED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER O O O O O O O O O O O O O O O O O O							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							-
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00					I	5.00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATI VE TO PROVIDER O O O S. 01	3.00						3.00
Program to Provider							
Solid		Program to Provider					1
Description	5.01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM	5.03			0		0	5. 03
S. 51 S. 52 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 O							
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATI VE TO PROGRAM		-			
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50				-			
- 5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 PROGRAM TO PROVIDER 6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) - 5. 98) - 6. 00 - 6. 00 - 7. 00 - 8. 00 Name of Contractor - 6. 00 - 7. 00 - 8. 00 - 8. 00 - 5. 98) - 6. 00 - 6. 00 - 7. 00 - 8. 00 - 6. 01 - 7. 00 - 7. 00 - 8. 00 - 7. 00 - 8. 00 - 8. 00 - 6. 00 - 9. 00 -				0			
6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 PROGRAM TO PROVIDER 0 0 6. 01 6. 02 PROVIDER TO PROGRAM 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 625, 109 0 7. 00 Contractor Name Contractor Number	5. 99			0		0	5. 99
the cost report. (1) PROGRAM TO PROVIDER 6. 01 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1. 00 2. 00 8. 00 Name of Contractor 8. 00	6 00						6.00
6. 01 PROGRAM TO PROVIDER 0 0 6. 01 0 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 625, 109 0 7. 00 0 7. 00 0 0 7. 00 0 0 0 0 0 0 0	0.00						0.00
6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1. 00 2. 00 8. 00 Name of Contractor 8. 00	6. 01			n		0	6, 01
7. 00 Total Medicare program liability (see instructions) 1,625,109 0 7.00 Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00				-			
Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00		· · · · · · · · · · · · · · · · · · ·				1	1
8.00 Name of Contractor 8.00					or Name	Contractor	
8.00 Name of Contractor 8.00						Number	
				1.	00	2. 00	
	8.00	Name of Contractor				1	8.00

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

Health Financial Systems

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

Provi der No.: 315525

| Period: | Worksheet G | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 6/1/2023 5:35 pm |

oni y)					6/1/2023 5: 35	pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					+
1.00	Cash on hand and in banks	529, 225	j (0	0	1.00
2.00	Temporary investments	0		0	l	
3.00	Notes receivable	0) (0	0	
4.00	Accounts receivable	1, 318, 001	1	0	0	
5.00	Other receivables	0		0	0	1
6. 00	Less: allowances for uncollectible notes and accounts receivable			J U	0	6. 00
7.00	Inventory			0	О	7. 00
8.00	Prepai d expenses	67, 672	2	o o	0	
9.00	Other current assets	-2, 126, 821		0	0	9.00
10.00	Due from other funds	0	1	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	-211, 923	(0	0	11.00
12. 00	FI XED ASSETS Land	1 0	1 (0	0	12.00
13. 00	Land improvements		1		1	
14. 00	Less: Accumulated depreciation		1		ĺ	
15. 00	Bui I di ngs	0		o o	Ō	
16.00	Less Accumulated depreciation	0) (0	0	16. 00
17. 00	Leasehold improvements	0	(0	0	1
18.00	Less: Accumulated Amortization	0	1	0	0	
19.00	Fixed equipment		1	0	0	1
20. 00 21. 00	Less: Accumulated depreciation Automobiles and trucks		1	0		
22. 00	Less: Accumulated depreciation			-		
23. 00	Major movable equipment				٥	
24. 00	Less: Accumulated depreciation			o o	Ö	
25. 00	Mi nor equi pment - Depreci abl e	0		0	0	25. 00
26. 00	Mi nor equipment nondepreciable	0) (0	0	
27. 00	Other fixed assets	0	1	0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0) (0	0	28. 00
29. 00	OTHER ASSETS Investments			0	0	29. 00
30.00	Deposits on Leases			-	·	
31.00	Due from owners/officers			o o	Ö	
32. 00	Other assets	0		o o	0	
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0) (0	0	33.00
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	-211, 923	(0	0	34.00
	Liabilities and Fund Balances					-
35. 00	CURRENT LIABILITIES Accounts payable	1 0) (0	35. 00
36. 00	Salaries, wages, and fees payable	217, 075	1			
37. 00	Payroll taxes payable	1		0	Ö	1
38. 00	Notes & Loans payable (Short term)	, o		o o	Ö	
39.00	Deferred income	0) (0	0	39.00
40.00	Accel erated payments	0				40.00
41.00	Due to other funds	0		0	0	
42.00	Other current liabilities	999, 463		0	l .	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) LONG TERM LIABILITIES	1, 216, 539	'	0	0	43. 00
44. 00	Mortgage payable			0	0	44.00
45. 00	Notes payable		1		·	1
46. 00	Unsecured Loans		1	o o	Ö	
47.00	Loans from owners:	0		0	0	47. 00
48. 00	Other long term liabilities	0) (0	0	
49. 00	OTHER (SPECIFY)	0	1	0	0	1
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	1, 216, 539	'	0 0	0	51.00
52. 00	General fund balance	-1, 428, 462	,			52. 00
53. 00	Specific purpose fund	1, 720, 402				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		1		0	
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58.00
E0 00	replacement, and expansion	1 420 443	,		,	F0 00
59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-1, 428, 462 -211, 923	1	0	0	
55. 50	[59]	211, 723]] 30.00
		'	•		,	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315525

					0 12/31/2022	6/1/2023 5:35	
		General	Fund	Speci al Pu	urpose Fund	Endowment Fund	piii
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		-518, 033		(1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-910, 433				2. 00
3.00	Total (sum of line 1 and line 2)		-1, 428, 466)	3. 00
4.00	Additions (credit adjustments)						4. 00
5.00	ROUNDI NG	4				0	5. 00
6. 00 7. 00		0		1 (1	0	6. 00 7. 00
7. 00 8. 00					1		8.00
9. 00		0			1		9. 00
10. 00	Total additions (sum of line 5 - 9)		1		΄	1	10.00
11. 00	Subtotal (line 3 plus line 10)		-1, 428, 462				11. 00
12. 00	Deductions (debit adjustments)		-1, 420, 402			ή	12. 00
13. 00	beddetrons (debrit day detiments)	0				0	13. 00
14. 00		0				0	14. 00
15. 00		0		l c		0	15. 00
16. 00		0		C		0	16. 00
17.00		O		C		0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0		(18. 00
19. 00	Fund balance at end of period per balance		-1, 428, 462		(19. 00
	sheet (Line 11 - line 18)			L			
		Endowment Fund	PI ant	Funa I			
		6. 00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0.00	7.00	0.00			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)						2. 00
3.00	Total (sum of line 1 and line 2)	O		C			3. 00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDI NG		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8. 00			0				8. 00
9. 00			0	_			9. 00
10.00	Total additions (sum of line 5 - 9)	0		C)		10.00
11.00	Subtotal (line 3 plus line 10)	0)		11.00
12. 00 13. 00	Deductions (debit adjustments)		0				12.00
14. 00			0				13. 00 14. 00
15. 00			0				15.00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0	J	c			18. 00
19. 00	Fund balance at end of period per balance						19. 00
50	sheet (Line 11 - line 18)]			
	•			•	•		•

Health Financial Systems	HARBOUR VIEW SENIOR LI	VING CENTER	In Lie	u of Form CMS-2540-10

Heal th	Financial Systems HARBOUR VIEW SENIOR LI	VING CENTE	ER	In Lie	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	F	Period: From 01/01/2022 To 12/31/2022		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		6, 419, 848	3	6, 419, 848	1. 00
2.00	NURSING FACILITY				0	2. 00
3. 00	ICF/IID		(0	3. 00
4.00	OTHER LONG TERM CARE		2, 385, 803		2, 385, 803	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		8, 805, 651	I	8, 805, 651	5. 00
	All Other Care Services					,
6.00	ANCILLARY SERVICES		320, 027		320, 027	6.00
7.00	CLINIC			0	1	7.00
8. 00 9. 00	HOME HEALTH AGENCY COST AMBULANCE			0	0	
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 00	FOHC			0	0	10.00
11. 00	CMHC			0	0	11. 00
12. 00	HOSPI CE				0	12.00
13. 00	OTHER (SPECIFY)				0	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	9, 125, 678	-	1	1
11.00	Worksheet G-3, Line 1)		7, 120, 070]	7, 120, 070	11.00
	Cost Center Description		•			
	'			1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				10, 001, 588	1.00
2.00	Add (Specify)			0		2. 00
3.00				0		3. 00
4.00				0		4. 00
5.00				0		5. 00
6.00				0		6. 00
7.00				0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)			_	0	
9.00	Deduct (Specify)			0		9. 00
10.00				0		10.00
11.00				0		11.00
12. 00 13. 00						12. 00 13. 00
14. 00	Total Deductions (Sum of lines 9 - 13)				0	
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				10, 001, 588	
15.00	Trotal operating Expenses (Sum of Times Fand 6, IIII has Time 14)				10,001,300	10.00

Health Financial Systems	HARBOUR VIEW SENIOR LI	VING CENT	ER		In Lie	u of Form CMS-2540-	10
OTATEMENT OF BATHERIT BENEFIT OF	ND ODEDATING EVERYORS			T			

Heal th	lth Financial Systems HARBOUR VIEW SENIOR LIVING CENTER		In Lieu of Form CMS-254		
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315525	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Preperty 6/1/2023 5:35	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1			9, 125, 678	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	5		276, 577	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			8, 849, 101	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		10, 001, 588	4. 00
5.00	Net income from service to patients (Line 3 minus 4)			-1, 152, 487	5. 00
	Other income:				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			408	7. 00
8.00	Revenues from communications (Telephone and Internet service)			0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			7, 300	
13. 00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other that	an patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of skilled nursing space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	REV MISC			8, 500	24. 00
24. 01	OTHER I NCOME			225, 846	24. 01
24. 50	COVI D-19 PHE Funding			0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)			242, 054	25. 00
26. 00	Total (Line 5 plus line 25)			-910, 433	26. 00
27. 00	Other expenses (specify)			0	27. 00
28. 00				l ol	28. 00
29. 00				o	29. 00
	Total other expenses (Sum of Lines 27 - 29)			o	
	Net income (or loss) for the period (Line 26 minus line 30)			-910, 433	