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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315101

Period:
From 01/01/2021
To 12/31/2021

Beriod:
Parts I, II & III
To 12/31/2021

Provider CCN: 315101

Period:
From 01/01/2021
To 12/31/2021

Provider CCN: 315101

					5/19/2022 8:20 am
PART I - COST I	REPORT STATUS				
Provi der	1. [ X ] Electronically prepared cost rep	ort		Date:	Ti me:
use only	2. [ ] Manually prepared cost report				
	3. [ 0 ] If this is an amended report ent	er the number	of times the provider	resubmitted th	is cost report
	3.01 [ ] No Medicare Utilization. Enter "	Y" for yes or	leave blank for no.		
Contractor	4. [ 1 ] Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[ N ] First	Cost Report for this	Provider CCN	
	(2) Settled without audit	8.[ N ] Last	Cost Report for this P	rovider CCN	
	(3) Settled with audit	9. NPR Date:	·		
	(4) Reopened	10.[ 0 ][f [i	ne 4, column 1 is "4":	— Enter number o	of times reopened
	(5) Amended		Vendor Code	4	·
	5. Date Received:	12.[ F ] Medi	care Utilization. Enter	 "F" for full,	"L" for low, or "N"

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JFK HARTWYCK AT CEDAR BROOK (315101) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	R 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	-4, 929	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	-4, 929	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 JFK HARTWYCK AT CEDAR BROOK In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315101 Peri od: Worksheet S-2 From 01/01/2021 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2021 5/19/2022 8: 20 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 1340 PARK AVE. PO Box: 1.00 2.00 City: PLAINFIELD State: NJ Zi p Code: 07060 2.00 3.00 County: UNI ON CBSA Code: 35084 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 JFK HARTWYCK AT CEDAR 315101 01/01/1973 N Р Ν 4.00 **BROOK** 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) 01/01/2021 12/31/2021 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 N 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 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 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 305 822 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 305, 822 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) 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 N 34.00 SNF-Based FQHC N 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 Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry mal practice insurance? (Y/N) Ν 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 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 41.00 List malpractice premiums and paid losses: 41.00 0 0 0

Heal th	Financial Systems	JFK HARTWYCK AT CED	AR BROOK	In Lie	u of Form CMS-2	2540-10
	COMPLEX INDENTIFICATION DATA From 01/01/2021 To 12/31/2021				Worksheet S-2 Part I Date/Time Pre 5/19/2022 8:2	pared:
					Y/N	U aiii
					1. 00	
	42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.					
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		N	43. 00
44.00	If line 43 is yes, enter the home offi	ce chain number and enter	the name and addres	s of the home		44. 00
	office on lines 45, 46 and 47.					
	1. 00	2. 00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	e and address of the	e home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Contr	actor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47.00	Ci ty:	State:	Zi p C	ode:		47. 00

Second   Provider No.: 315101   Provider No	Heal th	Financial Systems	JFK HARTWYCK AT CED	AR BROOK		In lie	eu of Form CMS	-2540-10
Part	SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILI			No.: 315101	Period: From 01/01/2021	Worksheet S- Part II Date/Time Pr	2 epared:
Semeral Instructions: For all to unan 1 responses enter in calcium 1, "Y" for Yes or "N" for No. For all the deale responses the format up to the deale of the cost capability of th							Date	20 am
1.00   lists the provider changed conversing is mediated by prior to the beginning of the cost reporting period? If column 1 is "Y", either the date of the change in column 2 (see   Y/R		responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" fo	or Yes or "N"			
1.00   2.00   3.00   3.00   2.00   3.00	1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter	ly prior to the beg the date of the cha	inning of nge in col	umn 2. (see			1. 00
column 1 is yes, enter in column 2 the date of termination and in column 3, "" for voluntary or "I for involuntary." 3.00 is the provider involved in business transactions, including management over the provider involved in business transactions, including management of the provider of								
relationships? (see instructions)		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 transac contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personne	of termination and tions, including ma ., chain home offic d to the provider o l, or members of th	in column nagement es, drug r its e board				2.00
Financial Data and Reports			ramily and other si	milar				
Financial Data and Reports   4,00   Column 1: Were the Financial statements prepared by a Certified Public   Y   A   4,00   Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)   17 no. see instructions   5.00   Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit   Y/N   Legal Oper.								
Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.  5.00 Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.  Approved Educational Activities  6.00 Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the N N N 6.00 Regal operator of the program? (Y/N) see instructions.  8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing N School and/or Allied Health Program? (Y/N) see instructions.  9.00 Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.  9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.  11.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.  9.01 In 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.  12.00 Have total beds available changed from prior cost reporting period? If "Y", see instructions.  13.00 Was the cost report prepared using the PS&R only If either col. I or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. I or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  15.00 If line 13 or 14 is "Y", then were allocations for the PS&R Report in Columns 2 and 4.  16.00 If line 13 or 14 is "Y", then were allocations for the PS&R Report in Columns 2 and 4.  17.00 If line 13 or 14 is "Y", then were allocations for the PS&R Report in Columns 2 and 4.  18.00 Was the cost report prepared only using the PS&R corrections of other PS&R Report information? If yes, see Instructions.							0.00	
those on the filed financial statements? If column 1 is "Y", submit    Part   P		Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	" for Audited, "C" te copy or enter da no, see instructio	for te ns.	·	A		4. 00 5. 00
Approved Educational Activities	0.00	those on the filed financial statements? If			·			0.00
Approved Educational Activities  6.00 Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: is the provider the N N N 6.00 Column 1: Were costs claimed for Allied Heal th Programs? (Y/N) see instructions. N N 7.00 Were costs claimed for Allied Heal th Programs? (Y/N) see instructions. N N 7.00 Were costs claimed for Allied Heal th Programs? (Y/N) see instructions. N N 8.00 School and/or Allied Heal th Program? (Y/N) see instructions. N N 7.00 If line 9 is "Y", did the provider's bad debts? (Y/N) see instructions. N 1.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting N 10.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 11.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 12.00 Have total beds available changed from prior cost reporting period? If "Y", see instructions. N 12.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 12.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 12.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 12.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 12.00 If line 13 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R N N N N 14.00 Was the cost report prepared using the PS&R N N N N N N N N N N N N N N N N N N N		7. 555						
legal operator of the program? (Y/N)   See instructions.   N     7.00   Nursing   N		Approved Educational Activities				1. 00	2.00	
We're costs claimed for Allied Health Programs? (Y/N) see instructions.   N   7.0.	6. 00		ool? (Y/N) Column 2	: Is the	provider the	N	N	6. 00
Bad Debts   Step Provider seeking relimbursement for bad debts? (Y/N) see instructions.   Y   9.0		Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri	ng the cost reporti		for Nursing			7. 00 8. 00
Bad Debts   Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.   Y   9.0		Co.   Co.	<u> </u>					
11.00   If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.   N   11.00		Is the provider seeking reimbursement for balfline 9 is "Y", did the provider's bad deb				st reporting	Y	9. 00 10. 00
12.00   Have total beds available changed from prior cost reporting period? If "Y", see instructions.   N   12.00	11. 00	If line 9 is "Y", are patient deductibles and	d/or coinsurance wa	ived? If "	Y", see inst	ructi ons.	N	11. 00
Description   Y/N   Date   Y/N	12. 00		cost reporting per	iod? If "Y				12. 00
PS&R Data  13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see Instructions.  17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			Descriptio	n				
13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.  17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:  N N N N N N N N N N N N N N N N N N N								
14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Corrections of other PS&R Report information? If yes, see instructions.  18.00 Was the cost report prepared only using the	13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			Y	04/21/2022	Y	13. 00
15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:  18.00 Was the cost report prepared only using the	14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and			N		N	14.00
16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:  18.00 Was the cost report prepared only using the	15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",			N		N	15. 00
adjustments made to PS&R data for Other? Describe the other adjustments:  18.00 Was the cost report prepared only using the  N N 18.00		If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.						16. 00
		adjustments made to PS&R data for Other? Describe the other adjustments:						17. 00
iprovider a records. The insert decirons.	18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.			N		N N	18. 00

Heal th	Financial Systems JF	FK HARTWYCK AT	CEDAR BROOK		In Lie	u of Form CMS-:	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY	Y HEALTH CARE	Provi der		Peri od: From 01/01/2021	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				To 12/31/2021	Date/Time Pre 5/19/2022 8:2	pared: 0 am
			1.	. 00	2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/	position	VARI OUS		VARI OUS		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 re	port	HUBCO HEALTH (	CARE GROUP			20. 00
	preparer.						
21.00	Enter the telephone number and email address of	of the cost	609-730-1980		COSTREPORTS@HUE	BCO. NET	21. 00
	report preparer in columns 1 and 2, respective	el y.					

Health Financial Systems JFK HARTWYCK AT SKILLED NURSING FACILITY HEALTH CARE JFK HARTWYCK AT CEDAR BROOK Provi der No.: 315101

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

				То	12/31/2021	Date/Time Pre 5/19/2022 8: 2	
		Part B			.,		
		Date					
		4. 00					
	PS&R Data						
13.00	Was the cost report prepared using the PS&R	04/21/2022					13. 00
	only? If either col. 1 or 3 is "Y", enter						
	the paid through date of the PS&R used to						
	prepare this cost report in cols. 2 and 4. (see Instructions.)						
14. 00	Was the cost report prepared using the PS&R						14. 00
14.00	for total and the provider's records for						14.00
	allocation? If either col. 1 or 3 is "Y"						
	enter the paid through date of the PS&R used						
	to prepare this cost report in columns 2 and						
	4.						
15. 00	If line 13 or 14 is "Y", were adjustments						15. 00
	made to PS&R data for additional claims that have been billed but are not included on the						
	PS&R used to file this cost report? If "Y",						
	see Instructions.						
16. 00							16. 00
	adjustments made to PS&R data for						
	corrections of other PS&R Report						
	information? If yes, see instructions.						
17. 00	If line 13 or 14 is "Y", then were						17. 00
	adjustments made to PS&R data for Other?						
18 00	Describe the other adjustments: Was the cost report prepared only using the						18. 00
10.00	provider's records? If "Y" see Instructions.						10.00
			3. 00				
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title		STAFF				19. 00
	held by the cost report preparer in columns 1	i, 2, and 3,					
20. 00	respectively. Enter the employer/company name of the cost r	renort					20. 00
20.00	preparer.	Срог с					20.00
21. 00	Enter the telephone number and email address	of the cost					21. 00
	report preparer in columns 1 and 2, respective						
	• • • • • • • • • • • • • • • • • • • •						•

Health Financial Systems JFK HARTWYCK AT CEDAR BROOK In Lieu of Form CMS-2540-10 Provider No.: 315101

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

Peri od: Worksheet S-3 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021

5/19/2022 8: 20 am Inpatient Days/Visits Title XVIII Component Number of Beds Bed Days Title V Title XIX Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 106 38, 690 0 1, 350 28, 041 1.00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 3.00 HOME HEALTH AGENCY COST O 4.00 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 7.00 8.00 Total (Sum of lines 1-7) 106 38, 690 1, 350 28, 041 8.00 Inpatient Days/Visits Di scharges Title XIX 0ther Title V Title XVIII Component Total 6.00 7.00 8.00 9. 00 10.00 1.00 SKILLED NURSING FACILITY 5, 025 34, 416 0 64 63 1. 00 NURSING FACILITY 0 2.00 0 2.00 0 LCE/LLD 3 00 3 00 4.00 HOME HEALTH AGENCY COST 0 4.00 5.00 Other Long Term Care 0 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 7 00 7.00 8.00 Total (Sum of lines 1-7) 5,025 34, 416 63 8.00 Average Length of Stay Di scharges 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 445.10 1.00 240 21.09 NURSING FACILITY 0.00 2.00 0 0.00 2.00 3.00 ICF/IID 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 5.00 0 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 7.00 7.00 8.00 Total (Sum of lines 1-7) 113 240 0.00 21.09 445.10 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16.00 17.00 18.00 19.00 20.00 1.00 SKILLED NURSING FACILITY 143. 40 64 59 127 1. 00 2.00 NURSING FACILITY 0.00 2.00 0 LCF/LLD 3.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 0.00 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 7 00 7 00 Total (Sum of lines 1-7) 143.40 59 127 8.00 64 8.00 Admi ssi ons Full Time Equivalent Component Total Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 250 0.00 96.63 1.00 NURSING FACILITY 2.00 2.00 0.00 0.00 0 3.00 ICF/IID 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0 0.00 0.00 5.00 6.00 SNF-Based CMHC 6.00 0.00 0.00 HOSPI CE 7.00 7.00 8.00 Total (Sum of lines 1-7) 250 96.63 0.00 8.00

					Γο 12/31/2021	Date/Time Pre 5/19/2022 8:2	
		Amount	Reclass. of			Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
4 00	SALARI ES	F 700 004		0 5 700 00	4 000 007 57	00.40	4 00
1.00	Total salaries (See Instructions)	5, 708, 094		5, 708, 09	•	l e	1.00
2.00	Physician salaries-Part A	0			0.00		2.00
3.00	Physician salaries-Part B	0			0.00		3.00
4.00	Home office personnel	0			0.00		4. 00
5.00	Sum of lines 2 through 4	5 700 004		0 5 700 00	0.00	l e	5.00
6.00	Revised wages (line 1 minus line 5)	5, 708, 094		0 5, 708, 09		l e	
7.00	Other Long Term Care	0			0.00		7. 00
8.00	HOME HEALTH AGENCY COST	0		0	0.00		
9.00	CMHC	0		O C	0.00	0.00	
10.00	HOSPI CE						10.00
	Other excluded areas	0		0	0.00		
12. 00	Subtotal Excluded salary (Sum of lines 7 through 11)	0		0	0.00	0.00	12. 00
13. 00	Total Adjusted Salaries (line 6 minus line	5, 708, 094		0 5, 708, 094	200, 996. 57	28 40	13. 00
10.00	12)	0,700,071		0,700,07	200, 770. 07	20. 10	10.00
	OTHER WAGES & RELATED COSTS		L				
14.00	Contract Labor: Patient Related & Mgmt	716, 753		0 716, 75	13, 848. 00	51. 76	14. 00
15. 00	Contract Labor: Physician services-Part A	0		ol (	0.00		15. 00
	Home office salaries & wage related costs	0		ol (	0.00	0.00	16. 00
	WAGE-RELATED COSTS			<u>'</u>			
17. 00	Wage-related costs core (See Part IV)	1, 460, 756		0 1, 460, 750	5		17. 00
18.00	Wage-related costs other (See Part IV)	57, 323		0 57, 32	3		18. 00
19.00	Wage related costs (excluded units)	0		ol	)		19. 00
	Physician Part A - WRC	0		ol (	)		20. 00
	Physician Part B - WRC	0		ol (	o		21.00
	Total Adjusted Wage Related cost (see	1, 518, 079		0 1, 518, 079	9		22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315101

						5/19/2022 8: 20	0 am
		Amount	Reclass. of	Adj usted		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	333, 314	0	333, 314	10, 888. 11	30. 61	2.00
3.00	Plant Operation, Maintenance & Repairs	141, 927	0	141, 927	6, 863. 66	20. 68	3.00
4.00	Laundry & Linen Service	0	0	) c	0.00	0.00	4.00
5.00	Housekeepi ng	0	0	) c	0.00	0.00	5. 00
6.00	Di etary	571, 243	0	571, 243	30, 932. 58	18. 47	6.00
7.00	Nursing Administration	351, 630	0	351, 630	7, 446. 29	47. 22	7.00
8.00	Central Services and Supply	33, 046	0	33, 046	2, 067. 00	15. 99	8. 00
9.00	Pharmacy	0	0	ol c	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	ol c	0.00	0.00	10.00
11.00	Soci al Servi ce	124, 950	0	124, 950	3, 576. 00	34. 94	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	154, 992	0	154, 992	7, 271. 11	21. 32	13.00
14. 00	Total (sum lines 1 thru 13)	1, 711, 102	0	1, 711, 102	69, 044. 75	24. 78	14. 00

Health Financial Systems	JFK HARTWYCK AT CEDAR BROOK	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315101	Peri od: Worksheet S-3
		From 01/01/2021   Part IV
		To 12/21/2021   Data/Timo Propared

	To 12/31/202		
		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	167, 971	3. 00
4.00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	896, 048	
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10. 00
11. 00	1	0	11. 00
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	1 3	0	13.00
14.00		0	14.00
15. 00		0	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	396, 737	
18. 00		0	18. 00
19. 00		0	19. 00
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation	0	21. 00
22. 00		0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 - 23)	1, 460, 756	24. 00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25. 00	FRINGE BENEFITS OTHER	57, 323	25. 00

Occupational Category Amount Fringe Adjusted Paid Hours Average	2 8: 20 am
Reported Benefits Salaries (col. Related to Wage (co	
1 + col. 2) Salary in col. col.	
3	
1.00 2.00 3.00 4.00 5.0	
Direct Salaries	
Nursing Occupations	
1.00 Registered Nurses (RNs) 1,623,951 431,893 2,055,844 33,323.40	51. 69 1. 00
2.00 Licensed Practical Nurses (LPNs) 694,849 184,796 879,645 21,659.00	40. 61 2. 00
3.00   Certified Nursing Assistant/Nursing   1,380,333   367,102   1,747,435   69,349.34	25. 20 3. 00
Assi stants/Ai des	
4.00   Total Nursing (sum of lines 1 through 3)   3,699,133   983,791   4,682,924   124,331.74	37. 66 4. 00
5. 00 Physi cal Therapi sts 148, 816 39, 578 188, 394 3, 749. 43	50. 25 5. 00
6. 00 Physi cal Therapy Assi stants 5, 705 1, 517 7, 222 168. 00	42. 99 6. 00
7. 00 Physi cal Therapy Ai des 0 0 0 0. 00	0.00 7.00
8.00   Occupational Therapists   98,856   26,291   125,147   2,790.47	44. 85 8. 00
9.00   Occupational Therapy Assistants 6,379 1,696 8,075 211.00	38. 27 9. 00
10.00 Occupational Therapy Aides 0 0 0 0.00	0.00 10.00
11. 00   Speech Therapists   38, 103   10, 134   48, 237   702. 00	58. 71 11. 00
12.00 Respiratory Therapists 0 0 0 0.00	0.00 12.00
13.00 Other Medical Staff 0 0 0 0.00	0.00 13.00
Contract Labor	
Nursing Occupations	
14.00 Registered Nurses (RNs) 134,750 134,750 975.00	38. 21 14. 00
15.00 Licensed Practical Nurses (LPNs) 46,589 46,589 672.00	59. 33   15. 00
16.00   Certified Nursing Assistant/Nursing   535,414   535,414   12,201.00	43. 88 16. 00
Assi stants/Ai des	
17.00   Total Nursing (sum of lines 14 through 16)   716,753   716,753   13,848.00	51. 76 17. 00
18.00   Physical Therapists 0 0 0.00	0.00 18.00
19.00 Physical Therapy Assistants 0 0 0.00	0.00 19.00
20. 00 Physi cal Therapy Ai des 0 0 0. 00	0.00 20.00
21.00   Occupational Therapists   0   0   0.00	0.00 21.00
22.00 Occupational Therapy Assistants 0 0 0.00	0.00 22.00
23.00 Occupational Therapy Aides 0 0 0.00	0.00 23.00
24.00   Speech Therapists       0       0       0.00	0.00 24.00
25. 00 Respiratory Therapists 0 0 0.00	0.00 25.00
26. 00   Other Medical Staff       0 <td< td=""><td>0.00   26.00</td></td<>	0.00   26.00

100		To 12/31/202	Date/lime Prepared:   5/19/2022 8:20 am
1.00			Days
100   100	1 00		
2.00			
Section   Sect		RVX	
Section   Sect			
7.00 RML 8.00 RML 9.00 RML 9.00 RML 9.00 RML 9.00 RML 11.00 RML			
B. 00			
10.00			
11.00   Right   11.00   Right   11.00   Right   12.00   Right   12.00   Right   13.00   Right			
12.00   RUA   112.00   RUA   113.00   RUC   RU			
13.00   RVC   114.00   RVG   RVG   114.00   RVG   RVG   114.00   RVG   RVG   119.00   RVG			
14.00   RVB			
16.00   RHC   10.00   RHG   17.00   RHG   17.00   RHG   18.00   RHA	14. 00		
17.00			
18 00			•
19,00   RMB			
21.00   RIMA   21.00   RIMA   22.00   RIMA   22.00   RIMA   23.00   RIMA   23.0			
22.00   RIB   22.00   RIA   23.00   24.00   ES3   25.00   ES3   25.00   ES3   24.00   ES3   25.00   ES3   25.00   ES3   25.00   ES3   25.00   ES3   25.00   ES3			
23 00   RIA   23 00   ES3   24 00   ES3   24 00   ES5   25 00   ES5   26			
24.00   ESS   24.00   ESS   25.00   ESS   25			
26. 00			24. 00
27.00     HE2   27.00     HE1   28.00     29.00     HE1   28.00     HE1   28.00     HE1   28.00     HE1   30.00     HE1   30.00     HE1   30.00     HE1   32.00     HE1   32.00     HE1   32.00     HE2   33.00     HE2   33.00     HE2   34.00     HE3   34			
28.00 30.00 30.00 31.00 30.00 31.00 32.00 32.00 34.00 34.00 34.00 35.00 36.00			
29.00   HD2			
31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 38.00 39.00 LD2 37.00 39.00 LD2 39.00 LD2 39.00 LC1 49.00 LC2 49.00 41.00 LC2 49.00 41.00 LBB1 42.00 43.00 44.00 CE1 44.00 CE2 43.00 45.00 CC2 44.00 CC3 46.00 CC1 46.00 CC2 47.00 CC3 CC2 47.00 CC3 CC3 CC3 CC3 CC3 CC3 CC4 CC4 CC5 CC5 CC5 CC5 CC5 CC5 CC6 CC7 CC7 CC7 CC8 CC7 CC8 CC8 CC8 CC8 CC9 CC9 CC9 CC9 CC9 CC9	29. 00	HD2	29. 00
32.00 34.00 34.00 35.00 36.00 36.00 36.00 36.00 37.00 38.00 38.00 39.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 LB1 40.00 LB2 41.00 42.00 42.00 43.00 44.00 44.00 44.00 44.00 45.00 46.00 46.00 46.00 47.00 48.00 682 49.00 55.00			
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 LE2 37. 00 39. 00 LD2 37. 00 39. 00 LC2 39. 00 LC2 39. 00 LC2 39. 00 LC2 39. 00 LC3 LC2 39. 00 LC4 LC3 40. 00 LC4 LC5 LC6 LC7			
34.00 35.00 36.00 36.00 37.00 38.00 38.00 38.00 38.00 39.00 30.00 40.00 40.00 40.00 40.00 41.00 42.00 42.00 43.00 44.00 44.00 45.00 46.00 47.00 48.00 48.00 48.00 49.00 60.00 48.00 60.00			
Section   Sect	34. 00	HB1	34.00
37 00   38 00   1.02   37 00   38 00   1.01   38 00   1.02   39 00   1.02   39 00   1.02   39 00   1.02   39 00   1.02   39 00   1.00			
38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 51. 00 51. 00 51. 00 52. 00 53. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 56. 00 57. 00 58. 00 58. 00 59. 00 50. 00 60			
100			
100     100     110     120	39. 00	LC2	39. 00
A2 00   A3 00   CE2			
43.00   CE2			
45. 00   CD2			
46. 00 47. 00 48. 00 CC2 47. 00 48. 00 CC2 47. 00 48. 00 CC1 48. 00 CC1 48. 00 CC2 47. 00 CC2 47. 00 CC2 48. 00 CC1 48. 00 CC1 48. 00 CC2 49. 00 CC2 50. 00 CC3 CC2 51. 00 CC4 51. 00 CC4 52. 00 CC4 52. 00 CC4 53. 00 SC3 SC3 SC3 SC3 SC3 SC4 SC5 SC5 SC6 SC0 SC5 SC7 SC8 SC8 SC7 SC8			
47.00   CC2   47.00   48.00   CC1   48.00   CC1   48.00   CC1   48.00   CC1   48.00   CC2   49.00   CC2   49.00   CC2   51.00   CC3   CC3   SE3   SE3.00   CC4   SE2   SE3   SE3.00   SE3   SE3   SE3.00   SE2   SE4.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE3   SE3.00			
48. 00   49. 00   50. 00   61. 00   62. 00   63. 00   65. 00   6			
49.00   CB2			
51. 00     CA2     51. 00       52. 00     SE3     52. 00       53. 00     SE3     53. 00       54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     SSA     58. 00       60. 00     I B2     59. 00       61. 00     I B1     60. 00       61. 00     I A2     61. 00       62. 00     I A1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     BA1     66. 00       67. 00     PE1     68. 00       69. 00     PD2     69. 00       70. 00     PD1     70. 00       71. 00     PC2     71. 00       72. 00     PB2     73. 00       74. 00     PB1     74. 00		CB2	49. 00
52. 00     CA1     52. 00       53. 00     SE3     53. 00       54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       62. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     BA1     66. 00       67. 00     PE2     67. 00       68. 00     PP1     68. 00       69. 00     PD2     69. 00       70. 00     PC2     71. 00       72. 00     PR2     73. 00       74. 00     PP1     74. 00			
53. 00       SE3       53. 00         54. 00       SE1       55. 00         55. 00       SE1       55. 00         56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       PE2       67. 00         68. 00       PE1       68. 00         69. 00       PD1       70. 00         70. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00			
54.00     SE2     54.00       55.00     SE1     55.00       56.00     SSC     56.00       57.00     SSB     57.00       58.00     SSA     58.00       59.00     IB2     59.00       60.00     IB1     60.00       61.00     IA2     61.00       62.00     IA1     62.00       63.00     BB2     63.00       64.00     BB1     64.00       65.00     BA1     66.00       67.00     BA1     66.00       67.00     PE2     67.00       68.00     PE1     68.00       69.00     PD1     70.00       71.00     PC2     71.00       72.00     PC2     71.00       73.00     PB2     73.00       74.00     PB1     74.00			
56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PP2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00	54. 00	SE2	54.00
57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       64. 00       65. 00         64. 00       65. 00       66. 00         66. 00       67. 00       66. 00         67. 00       68. 00       69. 00         70. 00       PD1       68. 00         69. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB1       74. 00			
58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       64. 00       65. 00         64. 00       65. 00       66. 00         66. 00       67. 00       68. 0         68. 00       PE1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PR2       73. 00         74. 00       PB1       74. 00			
59. 00         60. 00         61. 00         62. 00         63. 00         64. 00         64. 00         65. 00         66. 00         67. 00         68. 00         69. 00         70. 00         70. 00         71. 00         72. 00         73. 00         74. 00			
61. 00 62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  61. 00 61. 00 62. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 6	59. 00	I B2	59.00
62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BA1 62. 00 BB2 63. 00 64. 00 BB1 64. 00 BB4 65. 00 BB4 66. 00 PE2 67. 00 PE1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PB2 PC3. 00 PB3 PB1 74. 00			
63. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BB2 BB1 64. 00 BA1 66. 00 BA1 66. 00 PE1 68. 00 PP1 70. 00 PP1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PB1 72. 00 PB1 74. 00	62.00		61.00
64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BB1 64. 00 BA2 65. 00 BA1 66. 00 PE2 67. 00 PE1 68. 00 PD2 70. 00 PD1 70. 00 PC2 71. 00 PC1 72. 00 PB2 73. 00 PB1 74. 00			
66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 RA1 66. 00 PE2 67. 00 PE1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 73. 00 PB2 73. 00 PB1 74. 00	64. 00	BB1	64. 00
67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PE2 67. 00 PB1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3 PC1 72. 00 PB2 73. 00 PB2 74. 00			
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 Ref (68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 PC1 72. 00 PC3 PC1 PC2 PC1 72. 00 PC3 PC1 PC2 PC1 PC3 PC3 PC3 PC3 PC3 PC3 PC3 PC3 PC4 PC5 PC7			
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PD2 PB1 F0. 00 F0.			
71. 00 72. 00 73. 00 74. 00 PB1 71. 00 72. 00 PB2 PB1 74. 00	69. 00	PD2	69.00
72. 00 73. 00 74. 00 PB1 72. 00 PB1 74. 00			
73. 00 74. 00 PB1 73. 00 74. 00		PC2	
74.00 PB1 74.00			
75. 00 PA2 75. 00	74. 00	PB1	74.00
	75. 00	PA2	75. 00

Health Financial Systems	JFK HARTWYCK AT CEDAR BR	OOK		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Prov	der No.		Peri od: From 01/01/2021	Worksheet S-7	7
				To 12/31/2021	Date/Time Pro 5/19/2022 8:2	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100.00
			Expenses	Percentage	Y/N	
			1.00	2. 00	3. 00	
A notice published in the Federal Register payments beginning 10/01/2003. Congress expenses. For lines 101 through 106: Entercolumn 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "Y with direct patient care and related expenses (See instructions)	<pre>xpected this increase to be in column 1 the amount of for each category to total for yes or "N" for no if t</pre>	used for the expo SNF revo he spend	r direct pense for e enue from ding refle	aatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	101. 00
102.00 Recruitment						101.00
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

Health Financial Systems	JFK HARTWYCK AT	CEDAR BROOK		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
				rom 01/01/2021		
				o 12/31/2021	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	5/19/2022 8: 20 Reclassi fi ed	U alli
cost center bescription	Jai ai i es	Other	+ col . 2)	ons	Tri al Balance	
			1 (01. 2)	Increase/Decre		
				ase (Fr Wkst	col. 4)	
				A-6)	33.1.1)	
	1.00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	<u> </u>			· · · · · · · · · · · · · · · · · · ·		
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES		305, 822	305, 822	2 0	305, 822	1. 00
3.00 00300 EMPLOYEE BENEFITS	0	1, 518, 079	1, 518, 079	0	1, 518, 079	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	333, 314	1, 858, 932	2, 192, 246	o	2, 192, 246	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	141, 927	452, 999	594, 926	o	594, 926	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	0	583, 306	583, 306	o	583, 306	6. 00
7. 00 00700 HOUSEKEEPI NG	0	84, 377	84, 377	o o	84, 377	7. 00
8. 00   00800 DI ETARY	571, 243	382, 739	953, 982	e o	953, 982	8. 00
9.00 00900 NURSING ADMINISTRATION	351, 630	24, 747	376, 377	o	376, 377	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	33, 046	325, 111	358, 157		358, 157	10.00
11. 00 01100 PHARMACY	0	36, 622	36, 622	o	36, 622	11. 00
13. 00   01300   SOCIAL   SERVICE	124, 950	1, 987	126, 937		126, 937	13. 00
15. 00 01500 PATIENT ACTIVITIES	154, 992	15, 648			170, 640	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS		.,		- 1	.,	
30. 00 03000 SKILLED NURSING FACILITY	3, 699, 133	374, 942	4, 074, 075	0	4, 074, 075	30.00
31.00 03100 NURSING FACILITY	0	0			0	31. 00
33.00 03300 OTHER LONG TERM CARE	0	0	ď	ol	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0	29, 920	29, 920	0	29, 920	40. 00
41. 00   04100   LABORATORY	o	5, 885	5, 885	o	5, 885	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	o	49, 873	49, 873	o	49, 873	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	89, 501	89, 501	0	89, 501	43. 00
44. 00 04400 PHYSI CAL THERAPY	154, 521	0	154, 521	0	154, 521	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	105, 235	0	105, 235	o	105, 235	45. 00
46. 00 04600 SPEECH PATHOLOGY	38, 103	0	38, 103	o	38, 103	46. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99, 729	99, 729	o	99, 729	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	o	211, 968	211, 968	o o	211, 968	49. 00
51. 00 05100 SUPPORT SURFACES	0	0	(	o	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
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	C	0	0	71. 00
73. 00 07300 CMHC	0	0	C	0	0	73. 00
SPECIAL PURPOSE COST CENTERS						
89.00 SUBTOTALS (sum of lines 1-84)	5, 708, 094	6, 452, 187	12, 160, 281	0	12, 160, 281	89. 00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(	1	0	90. 00
91.00 09100 BARBER & BEAUTY SHOP	0	2, 099	2, 099	이	2, 099	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 PATI ENTS' LAUNDRY	0	0	(	0	0	94. 00
95.00 09500 OTHER NONREIMBURSABLE COST	0	0	(	0	0	95. 00
100. 00 TOTAL	5, 708, 094	6, 454, 286	12, 162, 380	0	12, 162, 380	100. 00

 
 Heal th Financial
 Systems
 JFK HARTWY

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315101 

				То	12/31/2021	Date/Time Prepared: 5/19/2022 8:20 am
	Cost Center Description	Adjustments to	Net Expenses			97 177 EBEE 81 EB 4111
	·	Expenses (Fr	For Allocation			
		Wkst A-8)	(col. 5 +-			
			col . 6)			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	305, 822			1.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 518, 079			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-349, 011	1, 843, 235			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	594, 926			5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	583, 306			6. 00
7. 00	00700 HOUSEKEEPI NG	0	84, 377			7. 00
8.00	00800 DI ETARY	0	953, 982			8.00
9.00	00900 NURSI NG ADMINI STRATI ON	0	376, 377			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	358, 157			10.00
11.00	01100 PHARMACY	0	36, 622			11.00
13.00	01300 SOCIAL SERVICE	0	126, 937			13.00
15. 00	01500 PATIENT ACTIVITIES	0	170, 640			15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		4 074 075	I		20.00
30.00	03000 SKILLED NURSING FACILITY	0	4, 074, 075			30.00
31.00	03100 NURSING FACILITY	0	0			31.00
33. 00	03300 OTHER LONG TERM CARE	0	0			33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	0	20, 020			40.00
40. 00 41. 00	04100 LABORATORY	0	29, 920 5, 885			40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY		49, 873			42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	89, 501			43. 00
44. 00	04400 PHYSI CAL THERAPY	0	154, 521			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	105, 235			45. 00
46. 00	04500 OCCUPATIONAL THERAPT	0	38, 103			46. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99, 729			48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS	0	211, 968			49. 00
51. 00	05100 SUPPORT SURFACES		211, 900			51.00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	O <sub>I</sub>			31.00
62. 00	06200 FQHC					62. 00
02.00	OTHER REIMBURSABLE COST CENTERS					02.00
70.00	07000 HOME HEALTH AGENCY COST	O	0			70.00
71. 00	07100 AMBULANCE	o	o			71.00
73. 00	07300 CMHC		o			73. 00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<sub>0</sub> 1			7 0. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-349, 011	11, 811, 270			89. 00
	NONREI MBURSABLE COST CENTERS		,,,	I.		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.00
91.00	09100 BARBER & BEAUTY SHOP	-176	1, 923			91. 00
92.00	09200 PHYSICIANS' PRIVATE OFFICES	o	O	l		92.00
93.00	09300 NONPALD WORKERS	o	o			93. 00
94.00	09400 PATIENTS' LAUNDRY	o	o			94. 00
95.00	09500 OTHER NONREIMBURSABLE COST		o			95. 00
100.00	TOTAL	-349, 187	11, 813, 193			100.00
		. '				•

Health Financial Systems	JFK HARTWYCK AT CED.	AR BROOK		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	,
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 8:2	
			Increases			
	Cost Center	r	Li ne #	Sal ary	Non Salary	
	2. 00		3. 00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	0	100.00
	of columns 4 and 5	must				
	equal sum of column	s 8 and				
	9)					

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	JFK HARTWYCK AT CED	AR BROOK		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315101	Peri od:	Worksheet A-6	
				From 01/01/2021		
				To 12/31/2021		
					5/19/2022 8: 2	0 am
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS JFK HARTWYCK AT CEDAR BROOK In Lieu of Form CMS-2540-10 Provi der No.: 315101

					10 12/31/2021	5/19/2022 8: 20	
			·	Acqui si ti on	5		
	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						
1.00	Land	1, 580, 000	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2. 00
3.00	Buildings and Fixtures	1, 761, 006	0		0	0	3. 00
4. 00	Building Improvements	0	0		0	0	4. 00
5. 00	Fi xed Equi pment	90, 630	0		0	0	5. 00
6.00	Movable Equipment	156, 111	0		0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	3, 587, 747	0		0	0	7. 00
8. 00	Reconciling Items	0	0		0	0	8. 00
9. 00	Total (line 7 minus line 8)	3, 587, 747	0		0 0	0	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
		/ 00	Assets 7.00				
	ANALYCIC OF CHANCES IN CADITAL ASSET DALANCES	6.00	7.00				
1 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						1 00
1. 00 2. 00		1, 580, 000	0				1. 00 2. 00
3.00	Land Improvements	1 7/1 00/	0				3. 00
4.00	Buildings and Fixtures	1, 761, 006	0				
5. 00	Building Improvements Fixed Equipment	90, 630	0				4. 00 5. 00
6. 00	Movable Equipment	156, 111	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	3, 587, 747	0				7. 00
8.00	Reconciling I tems	3, 367, 747	0				7. 00 8. 00
9. 00	Total (line 7 minus line 8)	3, 587, 747	0				9. 00
9.00	Tiotal (Title / IIIITius Title 8)	3, 587, 747	U	I			9.00

Peri od: Worksheet A-8 

				10 12/31/2021	5/19/2022 8: 2	
				Expense Classification on		
				To/From Which the Amount is		
				Toy I I dill limit dir tind / limburt 1 d	to bo haj dotod	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Allount	Cost center	LITTE NO.	
		1.00	2.00	3.00	4. 00	
1. 00	Investment income on restricted funds	B		ADMI NI STRATI VE & GENERAL	4.00	1. 00
1.00	(chapter 2)	D	-2, 409	ADMINISTRATIVE & GENERAL	4.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2.00
2.00	8)		0		0.00	2.00
3.00	1 - /		0		0.00	3. 00
4. 00	Refunds and rebates of expenses (chapter 8)	4	0			4.00
4.00	Rental of provider space by suppliers (chapter 8)		0		0.00	4.00
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
5.00	(chapter 21)		0		0.00	3.00
6. 00	Television and radio service (chapter 21)		_		0.00	6. 00
7. 00	1	4	0		0.00	7. 00
8.00	Parking lot (chapter 21)	A-8-2	0		0.00	8.00
8.00	Remuneration applicable to provider-based	A-8-2	0			8.00
0.00	physician adjustment		_		0.00	9. 00
9.00	Home office cost (chapter 21)		0		0.00	
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)	4.0.4	007.070			40.00
12. 00	Adjustment resulting from transactions with	A-8-1	337, 073			12. 00
40.00	related organizations (chapter 10)				0.00	40.00
13. 00	Laundry and linen service		0		0.00	
14. 00	Revenue - Employee meals	4	0		0.00	
15. 00	Cost of meals - Guests		0		0.00	
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
47.00	patients					47.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	1
19. 00	Vending machines		0		0.00	•
20. 00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments			l		
22. 00	Utilization reviewphysicians' compensation		0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	2. 00	
25. 00			0		0.00	1
25. 01	AMBULANCE	A		ADMINISTRATIVE & GENERAL	4. 00	1
25. 02	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	4.00	
25. 03	COLLECTION FEES	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	BAD DEBTS	A	-659, 651	ADMINISTRATIVE & GENERAL	4.00	25. 04
25. 05	BARBER AND BEAUTY	В	-176	BARBER & BEAUTY SHOP	91.00	25. 05
25. 06			0		0.00	25. 06
100.00	Total (sum of lines 1 through 99) (Transfer		-349, 187			100. 00
	to Worksheet A, col. 6, line 100)					

<sup>(1)</sup> 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.

JFK HARTWYCK AT CEDAR BROOK

Health Financial Systems JFK HARTWYCK AT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315101 OFFICE COSTS

OFFICE	COSTS				To 12/31/2021 Date/Time Pro 5/19/2022 8:2	
		Line No.		Center	Expense Items	
	DART I GOOTS INSURED AND ADMISTRENTS RESULT	1.00		00	3.00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	INS WITH RELATE	D ORGANIZATIONS OR	
1.00	CEATWIED HOWE OFFICE COSTS.	4. 00	ADMI NI STRATI VE	& GENERAL	BUS OFFICE - SALARIES	1.00
2. 00		4. 00	ADMI NI STRATI VE	& GENERAL	TRANSFER BUS OFFICE - ALLOCATION OF	2. 00
3. 00		44.00	PHYSICAL THERA	.DV	EXP REHAB - SHARED STAFF SALARY	3.00
4. 00			SPEECH PATHOLO		REHAB - SALARI ES ALLOCATION	4. 00
5. 00			EMPLOYEE BENEF		REHAB - FRINGE BENEFIT	5. 00
6. 00		11. 00	PHARMACY		ALLOCATION NURISNG - OTC (NON-LEGEND	6. 00
7. 00		4.00	ADMI NI STRATI VE	. CENEDAL	DRUGS) MANAGEMENT FEES	7. 00
8. 00			DRUGS CHARGED		PHARMACY EXP (LEGEND DRUGS)	8. 00
9. 00			INTRAVENOUS TH		PHARMACY - SOLUTIONS IV	9. 00
9. 01			INTRAVENOUS TH		IV SOLUTIONS	9. 01
9. 02			ADMI NI STRATI VE	& GENERAL	AMBULANCE	9. 02
9. 03 9. 04			LABORATORY EMPLOYEE BENEF	TITC	LABORATORY FRINGE BENEFIT ALLOCATION	9. 03 9. 04
9. 04 9. 05			EMPLOYEE BENEF		HOSPITALIZATION PREMIUMS	9.04
9. 06			ADMI NI STRATI VE		HOSP CORP ALLOC - INS	9. 06
9. 07			ADMI NI STRATI VE		MEDICAL DIRECTOR	9. 07
9. 08		4. 00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE	9. 08
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.					10.00
	12.	Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col . 5)		
		4. 00	5 5. 00	6. 00	-	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:				D ORGANI ZATI ONS OR	
1.00	CEATIVIED HOWE OFFICE COSTS.	34, 049	34, 049	C		1.00
2.00		30, 986	30, 986	o c	)	2. 00
3.00		51, 218				3. 00
4. 00 5. 00		38, 103 3, 655				4. 00 5. 00
6. 00		36, 322		1		6. 00
7. 00		321, 027				7. 00
8.00		201, 447				8. 00
9.00		17, 308				9. 00
9. 01		32, 565			1	9. 01
9. 02 9. 03		0 4, 526	00,			9. 02 9. 03
9. 04		18, 872				9. 04
9. 05		896, 048			)	9. 05
9. 06		231, 705				9. 06
9. 07		18, 000	18, 000		1	9. 07
9. 08 10. 00	TOTALS (sum of lines 1-9). Transfer column	337, 462 2, 273, 293	1, 936, 220	337, 462 337, 073		9. 08 10. 00
10.00	6, line 100 to Worksheet A-8, column 3, line	2,213,293	1, 730, 220	, 337,073		10.00
	12.					

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315101 Peri od: Worksheet A-8-1 From 01/01/2021 OFFICE COSTS Parts I-II 12/31/2021 Date/Time Prepared:

				5/19/2022 8: 20	<u>) am </u>
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/O	R HOME OFFICE:			

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

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

1.00	В	0.	00 1.00
2.00	В	0.	00 2.00
3.00	В	0.	00 3.00
4.00	В	0.	00 4.00
5. 00	В	0.	00 5.00
6. 00		0.	00 6.00
7. 00		0.	00 7.00
8. 00		0.	00 8.00
9. 00		0.	00 9.00
10. 00		0.	00 10.00
100.00 G. Other (financial or non-financial)		0.	00 100.00
speci fy:			

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

Rel ated Organi	Related Organization(s) and/or Home Office				
Name	Percentage of	Type of Business			
1.5	Ownershi p	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
4.00	5.00	6. 00	1		

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

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

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

1.00		COMMUNITY HOSPITAL GROUP	0.00	HEALTHCARE	1.00
2.00		HARTWYCK AT OAKTREE	0.00	HEALTHCARE	2.00
3.00		HMH NETWORK, INC.	0.00	HEALTHCARE	3. 00
4.00		HMH/QMC	0.00	HEALTHCARE	4. 00
5.00		HMH RESIDENTIAL CARE, INC.	0.00	HEALTHCARE	5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100. 00
	speci fy:				

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

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315101

				To	12/31/2021	Date/Time Pre 5/19/2022 8: 20	
			CAPI TAL			37 197 2022 8. 2	J alli
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FI XTURES	BENEFITS		& GENERAL	
		Allocation					
		(from Wkst A					
		col. 7) 0	1. 00	3.00	3A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	3.00	JA	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	305, 822	305, 822				1.00
3.00	00300 EMPLOYEE BENEFITS	1, 518, 079	0	1, 518, 079			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 843, 235	39, 758		1, 971, 639	1, 971, 639	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	594, 926	21, 647	37, 746	654, 319		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	583, 306	4, 984	0	588, 290	117, 857	6. 00
7.00	00700 HOUSEKEEPI NG	84, 377	4, 996	0	89, 373	17, 905	7. 00
8.00	00800 DI ETARY	953, 982	25, 217	151, 923	1, 131, 122	226, 607	8. 00
9.00	00900 NURSING ADMINISTRATION	376, 377	2, 156		472, 050		9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	358, 157	0	8, 789	366, 946		10.00
11. 00	01100 PHARMACY	36, 622	0	0	36, 622	7, 337	11. 00
13. 00	01300 SOCIAL SERVICE	126, 937	2, 156		162, 324	32, 520	13. 00
15. 00	01500 PATIENT ACTIVITIES	170, 640	8, 508	41, 220	220, 368	44, 148	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 074 075	470.000	000 704	F 004 000	4 047 007	00.00
30.00	03000 SKILLED NURSING FACILITY	4, 074, 075	173, 222	983, 791	5, 231, 088		30.00
31. 00 33. 00	03100 NURSING FACILITY 03300 OTHER LONG TERM CARE	0	0	0	0	1	31. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	l d	U	l d	0	0	33.00
40. 00	04000 RADI OLOGY	29, 920	0	0	29, 920	5, 994	40. 00
41. 00	04100 LABORATORY	5, 885	0	0	5, 885		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	49, 873	0	0	49, 873	9, 991	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	89, 501	0	o o	89, 501	17, 930	43. 00
44.00	04400 PHYSI CAL THERAPY	154, 521	17, 204	41, 095	212, 820	42, 636	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	105, 235	0	27, 987	133, 222	26, 689	45. 00
46.00	04600 SPEECH PATHOLOGY	38, 103	0	10, 134	48, 237	9, 664	46. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	99, 729	4, 902	0	104, 631	20, 962	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	211, 968	1, 072	0	213, 040	42, 680	49. 00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
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		71.00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
89. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	11, 811, 270	305, 822	1, 518, 079	11, 811, 270	1, 971, 254	89. 00
69.00	NONREI MBURSABLE COST CENTERS	11,011,270	303, 622	1, 310, 079	11,011,270	1, 9/1, 234	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	0	0	0	90.00
91. 00	09100 BARBER & BEAUTY SHOP	1, 923	0	0	1, 923	385	91. 00
92. 00	09200 PHYSI CI ANS' PRI VATE OFFI CES	1, 723	0	ا	1, 7 <u>2</u> 9	0	92.00
93. 00	09300 NONPALD WORKERS	l o	0	Ö	0	Ö	93. 00
94. 00	09400 PATI ENTS' LAUNDRY	l	0	Ö	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	o	0	O	0	0	95. 00
98. 00	Cross Foot Adjustments	o	0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	) TOTAL	11, 813, 193	305, 822	1, 518, 079	11, 813, 193	1, 971, 639	100. 00

 Provider No.: 315101
 Period: From 01/01/2021 Part I To 12/31/2021
 Worksheet B Part I Date/Time Prepared: Date

				То	12/31/2021		
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/19/2022 8: 2 NURSI NG	U alli
	oost contor boson per on	OPERATION,	LINEN SERVICE	11000EREEL THO	DILIMI	ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS					
		5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	785, 404					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	16, 017	722, 164				6. 00
7. 00	00700 HOUSEKEEPI NG	16, 055		.20,000			7. 00
8.00	00800 DI ETARY	81, 032		13, 266	1, 452, 027	l .	8. 00
9.00	00900 NURSI NG ADMINI STRATI ON	6, 929	0	1, 134	0	574, 683	1
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10. 00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
13. 00	01300 SOCI AL SERVI CE	6, 929		.,	0	0	13. 00
15. 00	01500 PATIENT ACTIVITIES	27, 339	0	4, 476	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	556, 622	722, 164	·	1, 452, 027	574, 683	30. 00
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	ı				1	
40. 00	04000 RADI OLOGY	0	1		0	_	
41. 00	04100 LABORATORY	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	55, 283	0	9, 051	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
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 752		2, 579	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	3, 446		564	0	0	49. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
(2.00	OUTPATIENT SERVICE COST CENTERS	İ	ĺ			1	(2.00
62. 00	06200 FOHC OTHER REIMBURSABLE COST CENTERS						62.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0			0	_	71.00
73.00	07300 CMHC	0	0	0	0	0	73.00
73.00	SPECIAL PURPOSE COST CENTERS	0		<u> </u>			73.00
89. 00	SUBTOTALS (sum of lines 1-84)	785, 404	722, 164	123, 333	1, 452, 027	574, 683	89. 00
07.00	NONREI MBURSABLE COST CENTERS	700, 404	122, 104	123, 333	1, 432, 027	374,003	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	O	0	0	90.00
91. 00	09100 BARBER & BEAUTY SHOP	0	0		0	_	91. 00
92. 00	09200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	Ö	0	o o	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	Ö	93. 00
94. 00	09400 PATIENTS' LAUNDRY	1 0	l 0	l o	n	ő	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	1 0	ا	Ö	ő	95. 00
98. 00	Cross Foot Adjustments	0	0	l o	0	ő	98. 00
99. 00	Negative Cost Centers	0	l 0	o	0	ő	99. 00
100.00		785, 404	722, 164	123, 333	1, 452, 027	574, 683	
							•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: Provi der No.: 315101

				1		5/19/2022 8:20	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	SOCIAL SERVICE	OTHER GENERAL SERVI CE	Subtotal	
		10.00	11. 00	13.00	15. 00	16.00	
<u> </u>	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	440, 459					10. 00
11. 00	01100 PHARMACY	0	43, 959				11. 00
13. 00	01300 SOCI AL SERVI CE	0	C	,			13. 00
15. 00	01500 PATIENT ACTIVITIES	0	C	0	296, 331		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	440, 459	43, 959	1	296, 331	10, 659, 356	30. 00
31. 00	03100 NURSING FACILITY	0	C		0	0	31. 00
33. 00	03300 OTHER LONG TERM CARE	0	C	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	C	1	0	35, 914	40. 00
41. 00	04100 LABORATORY	0	C	1	0	7, 064	41. 00
42. 00	04200   NTRAVENOUS THERAPY	0	C	1	0	59, 864	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	0	0	107, 431	43.00
44. 00	04400 PHYSI CAL THERAPY	0	C	0	0	319, 790	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	C		0	159, 911	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	C		0	57, 901	46. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	143, 924	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	C	1	0	259, 730	49. 00
51. 00	05100 SUPPORT SURFACES	0	C	0	0	0	51. 00
(2.00	OUTPATIENT SERVICE COST CENTERS 06200 FQHC			T			(2.00
62. 00	OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	O	C	0	0	0	70. 00
71.00	07100 AMBULANCE		C			0	71.00
73.00	07300 CMHC		C	1		0	73.00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		91 0	9	0	73.00
89. 00	SUBTOTALS (sum of lines 1-84)	440, 459	43, 959	202, 907	296, 331	11, 810, 885	89. 00
07.00	NONREI MBURSABLE COST CENTERS	440, 437	43, 737	7 202, 707	270, 331	11, 010, 003	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	C	o l	0	0	90. 00
91. 00	09100 BARBER & BEAUTY SHOP		C			2, 308	91.00
92. 00	09200 PHYSI CLANS' PRI VATE OFFI CES		Č		ا	2, 300	92. 00
93. 00	09300 NONPAI D WORKERS		C		0	0	93. 00
94. 00	09400 PATIENTS' LAUNDRY		Ċ	ا م	ام	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST		Ċ	ا م	ام	0	95. 00
98. 00	Cross Foot Adjustments			]	ام	0	98. 00
99. 00	Negative Cost Centers		C	ol o	ol	0	99.00
100.00		440, 459	43, 959	202, 907	296, 331	11, 813, 193	
	•	,		•			•

			5/19/2022 8: 2	20 am
Cost Center Description	Post Stepdown	Total		
	Adjustments			
	17. 00	18. 00		
GENERAL SERVICE COST CENTERS				
1.00   00100   CAP REL COSTS - BLDGS & FLXTURES				1.00
3.00   00300   EMPLOYEE BENEFITS				3. 00
4.00   00400   ADMINISTRATIVE & GENERAL				4. 00
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				9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY		İ		10.00
11. 00 01100 PHARMACY				11.00
13. 00 01300 SOCIAL SERVICE				13. 00
15. 00 01500 PATIENT ACTIVITIES				15. 00
INPATIENT ROUTINE SERVICE COST CENTERS				1
30. 00 03000 SKILLED NURSING FACILITY	0	10, 659, 356		30.00
31. 00 03100 NURSING FACILITY	o	0		31. 00
33. 00 03300 OTHER LONG TERM CARE		o		33. 00
ANCI LLARY SERVICE COST CENTERS	<u> </u>	O <sub>I</sub>		33.00
40. 00   04000 RADI OLOGY	0	35, 914		40.00
41. 00   04100   LABORATORY		7, 064		41. 00
42. 00   04200   I NTRAVENOUS THERAPY		59, 864		42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY		107, 431		43. 00
44. 00 04400 PHYSI CAL THERAPY		319, 790		44. 00
45. 00 04400 OCCUPATI ONAL THERAPY		159, 911		45. 00
46. 00   04600   SPEECH PATHOLOGY		57, 901		46.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		143, 924		48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS				49.00
51. 00   05100   SUPPORT SURFACES	0	259, 730 0		51.00
OUTPATIENT SERVICE COST CENTERS	l U	U		1 51.00
62. 00 06200 FQHC				62. 00
OTHER REIMBURSABLE COST CENTERS				1 62.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0		70.00
71. 00   07100   AMBULANCE		0		71.00
73. 00   07100   AMBOLANCE 73. 00   07300   CMHC		0		73.00
SPECIAL PURPOSE COST CENTERS	J U	U		73.00
89.00 SUBTOTALS (sum of lines 1-84)	0	11, 810, 885		89. 00
NONREI MBURSABLE COST CENTERS	<u> </u>	11, 010, 000		1 89.00
		0		90.00
	0	0		
91. 00 09100 BARBER & BEAUTY SHOP	0	2, 308		91.00
92. 00 09200 PHYSI CLANS' PRI VATE OFFI CES	0	0		92.00
93. 00   09300   NONPAI D   WORKERS	0	0		93.00
94. 00   09400   PATI ENTS' LAUNDRY	0	0		94. 00
95. 00 09500 OTHER NONREIMBURSABLE COST	0	0		95. 00
98.00 Cross Foot Adjustments	0	0		98. 00
99.00 Negative Cost Centers	0	0		99. 00
100. 00 TOTAL	0	11, 813, 193		100. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315101

				То	12/31/2021	Date/Time Prep 5/19/2022 8:20	
			CAPI TAL			37 177 2022 0. 20	J dill
			RELATED COSTS				
	Cost Center Description	Directly	BLDGS &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	<b>'</b>	Assigned New	FI XTURES		BENEFITS	& GENERAL	
		Capi tal					
		Related Costs					
		0	1.00	2A	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	T .	0		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	39, 758	· ·	0	39, 758	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	21, 647	21, 647	0	2, 643	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	4, 984	· ·	0	2, 377	6. 00
7.00	00700 HOUSEKEEPI NG	0	4, 996	· ·	0	361	7. 00
8.00	00800 DI ETARY	0	25, 217	25, 217	0	4, 570	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	2, 156	2, 156	0	1, 907	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	1, 482	10.00
11. 00	01100 PHARMACY	0	0	0	0	148	11. 00
13.00	01300 SOCI AL SERVI CE	0	2, 156	2, 156	0	656	13.00
15. 00	01500 PATIENT ACTIVITIES	0	8, 508	8, 508	0	890	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	173, 222		0	21, 131	30. 00
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	, ,					
40. 00	04000 RADI OLOGY	0	0		0	121	40. 00
41. 00	04100 LABORATORY	0	0	-	0	24	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0		0	201	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	362	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	17, 204		0	860	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	538	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0		0	195	46. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 902	· ·	0	423	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	1, 072		0	861	49. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
(2.00	OUTPATIENT SERVICE COST CENTERS  06200 FOHC						42.00
62. 00	OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE		0		0	0	71.00
73. 00	07300 CMHC		0		0	0	73.00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	O	<u> </u>		0	73.00
89. 00	SUBTOTALS (sum of lines 1-84)	0	305, 822	305, 822	0	39, 750	89. 00
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	303, 022	303, 022		37, 130	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	o	0	0	90. 00
91. 00	09100 BARBER & BEAUTY SHOP	0	0		0	8	91. 00
92. 00	09200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	o	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	o	0	0	93. 00
94. 00	09400 PATIENTS' LAUNDRY	l o	n	Ö	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	l o	n	Ö	0	0	95. 00
98. 00	Cross Foot Adjustments		J	l o	Ü	Ŭ	98. 00
99. 00	Negative Cost Centers		0	o	0	0	99. 00
100.00		0	305, 822	-	0	39, 758	

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

				10	12/31/2021	5/19/2022 8:20	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	Jaili
	cost center bescription	OPERATION,	LINEN SERVICE	11003EKEELTING	DILIANI	ADMI NI STRATI ON	
		MAINT. &	2111211 021111 02				
		REPAI RS					
		5. 00	6.00	7.00	8. 00	9. 00	
-	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	24, 290	)				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	495					6. 00
7.00	00700 HOUSEKEEPI NG	497	0	5, 854			7. 00
8.00	00800 DI ETARY	2, 506	0	630	32, 923		8. 00
9.00	00900 NURSING ADMINISTRATION	214	. 0	54	0	4, 331	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
13.00	01300 SOCIAL SERVICE	214	. 0	54	0	0	13.00
15.00	01500 PATIENT ACTIVITIES	846	0	212	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	17, 214	7, 856	4, 325	32, 923	4, 331	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	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	1, 710	0	430	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
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	487	0	122	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	107	0	27	0	0	49.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
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
	SPECIAL PURPOSE COST CENTERS						
89. 00	SUBTOTALS (sum of lines 1-84)	24, 290	7, 856	5, 854	32, 923	4, 331	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0		90. 00
91. 00	09100 BARBER & BEAUTY SHOP	0	0	0	0	0	91. 00
92. 00	09200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS' LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	24, 290	7, 856	5, 854	32, 923	4, 331	100. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315101

				T	o 12/31/2021	Date/Time Pre 5/19/2022 8:2	
					OTHER GENERAL	37 1 77 2022 0. 2	o alli
					SERVI CE		
	Cost Center Description	CENTRAL	PHARMACY	SOCIAL SERVICE	PATI ENT	Subtotal	
		SERVICES &			ACTIVITIES		
		SUPPLY					
	I	10.00	11. 00	13. 00	15. 00	16. 00	
4 00	GENERAL SERVICE COST CENTERS			T			4 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00
8. 00 9. 00	00900 NURSI NG ADMI NI STRATI ON						8. 00
10.00	1	1 400					9.00
	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	1, 482	1.40	,			10.00
11.00	l l	0	148	1			11. 00
13. 00 15. 00	01300 SOCIAL SERVICE	0	(		I I		13.00
15.00	O1500 PATIENT ACTIVITIES	U_		) <u> </u>	10, 456		15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   SKILLED NURSING FACILITY	1, 482	148	2 000	10 454	274 140	20.00
30.00	1			1	I	276, 168	30.00
31.00	03100 NURSING FACILITY	0	(			0	31. 00
33. 00	03300 OTHER LONG TERM CARE	U		) <u> </u>	ıj U	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	0	(		ol	101	40. 00
41. 00	04100 LABORATORY		(	1	- I	121 24	41. 00
41.00	04200 I NTRAVENOUS THERAPY		(	1		201	41.00
43. 00	04300 OXYGEN (INHALATION) THERAPY				1	362	43. 00
44. 00	04400 PHYSI CAL THERAPY				1	20, 204	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY				1	538	45. 00
46. 00	04600 SPEECH PATHOLOGY				1	195	46. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS				=	5, 934	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		(	1	- 1	2, 067	49. 00
51. 00	05100 SUPPORT SURFACES					2,007	51.00
31.00	OUTPATIENT SERVICE COST CENTERS	٩		,	۷	0	31.00
62. 00	06200 FQHC						62. 00
02.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		02.00
70.00	07000 HOME HEALTH AGENCY COST	0	C		ol	0	70.00
71. 00	07100 AMBULANCE	0	C			0	71. 00
73. 00	07300 CMHC	0	C		1	0	73. 00
	SPECIAL PURPOSE COST CENTERS	-1	-	-	-1		
89. 00	SUBTOTALS (sum of lines 1-84)	1, 482	148	3, 080	10, 456	305, 814	89. 00
	NONREI MBURSABLE COST CENTERS	, , , ,			, , , , , , ,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	) 0	0	0	90.00
91.00	09100 BARBER & BEAUTY SHOP	O	C		o	8	91.00
92.00	09200 PHYSICIANS' PRIVATE OFFICES	O	Č	) c	0	0	92.00
93.00	09300 NONPALD WORKERS	l	C	) c	o	0	93. 00
94.00	09400 PATIENTS' LAUNDRY	O	Č		o	0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST	O	Č		o	0	95. 00
98. 00	Cross Foot Adjustments		Č	)	0	0	98. 00
99. 00	Negative Cost Centers		Č	) c	0	0	99. 00
100.00	1 1 3	1, 482	148	3, 080	10, 456	305, 822	100.00
	•			•			•

Cost Center Description					5/19/2	022 8: 20 am
17.00   18.00   18.00		Cost Center Description	Post Step-Down	Total		
SENERAL SERVICE COST CENTERS			Adjustments			
1. 00			17. 00	18. 00		
3.00 00300 [AURDOVEE REMEITS		GENERAL SERVICE COST CENTERS				
4. 00   00400   ADMIN STRATI VE & GENERAL   5. 00   00500   PLANT OPERATION, MAINT, & REPAIRS   5. 00   00500   PLANT OPERATION, MAINT, & REPAIRS   6. 00   00500   PLANT OPERATION, MAINT, & REPAIRS   7. 00   0700   00700   HOUSEKEEP ING   8. 00   00800   DETARY   8. 00   00800   DETARY   8. 00   00800   DETARY   8. 00   00800   DETARY   8. 00   00900   NURSING ADMINISTRATION   9. 00   00900   NURSING ADMINISTRATION   9. 00   00900   NURSING ADMINISTRATION   11. 00   11. 00   11000   PLANTEN ACTIVITIES   13. 00   13. 00   13000   SOCI AL SERVICE S & SUPPLY   11. 00   13. 00   13000   SOCI AL SERVICE COST CENTERS   15. 00   15. 00   15. 00   NURSING FACILITY   0   276, 168   30. 00   30. 00   30. 00   30. 00   NURSING FACILITY   0   0   0   31. 00   33. 00	1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1. 00
5.00	3.00	00300 EMPLOYEE BENEFITS				3. 00
6. 00   00600   LAUNDRY & LINEN SERVICE	4.00	00400 ADMINISTRATIVE & GENERAL				4. 00
7. 00	5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5. 00
7. 00	6.00	00600 LAUNDRY & LINEN SERVICE				6.00
8. 00	7. 00					7. 00
9. 00   00900   NURSI NG ADMINI STRATI ON   9. 00   10. 0						
10.00						
11.00						
13. 00   01300   SOCI AL SERVICE     13. 00   01500   PATIENT ACTIVITIES						
15. 00     1500   PATI ENT ACTIVITIES						
INPATE BNT ROUTINE SERVICE COST CENTERS   30.00   330.00   SKILLED NURSING FACILITY   0   276, 168   30.00   31.00   330.00   SKILLED NURSING FACILITY   0   0   0   31.00   33.00   330.00   SKILLED NURSING FACILITY   0   0   0   0   31.00   33.00   330.00   SKILLED NURSING FACILITY   0   0   0   0   33.00   ANGILLARY SERVICE COST CENTERS						<b>I</b>
30. 00   03000   SKI LLED NURSI NG FACILITY   0   0   0   0   31. 00   031. 00   03100   NURSI NG FACILITY   0   0   0   0   0   31. 00   033. 00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   0   0   0	15.00					15.00
31. 00   03100   NURSI NG FACILITY	20.00			27/ 1/0		20.00
33. 00   0300   OTHER LONG TERM CARE   0   0   0   0   0   0   0   0   0						
ANCILLARY SERVICE COST CENTERS  40. 00 0 04000 RADI OLOGY 41. 00 04000 RADI OLOGY 41. 00 04000 RADI OLOGY 42. 00 04200 INTRAVENOUS THERAPY 42. 00 04200 INTRAVENOUS THERAPY 43. 00 04300 OXYGEN (INHALATI ON) THERAPY 44. 00 04400 PHYSI CAL THERAPY 45. 00 04400 PHYSI CAL THERAPY 46. 00 04400 PHYSI CAL THERAPY 47. 00 04500 OCCUPATI ONAL THERAPY 48. 00 04500 OCCUPATI ONAL THERAPY 49. 00 04500 OCCUPATI ONAL THERAPY 40. 00 04500 DEPICE PATHOLOGY 41. 00 04500 ORDICAL SUPPLIES CHARGED TO PATI ENTS 40. 00 04500 DRUGS CHARGED TO PAT		I I		- 1		l l
40. 00   04000   RADI OLOGY	33. 00		0	0		33. 00
41. 00						
42. 00 04200   INTRAVENOUS THERAPY 0 201 42. 00 43. 00 04300   OXYGEN (INHALATION) THERAPY 0 362 43. 00 44. 00 04400   PHSI CAL THERAPY 0 20, 204 44. 00 45. 00 04500   OCCUPATIONAL THERAPY 0 538 45. 00 46. 00 04500   OCCUPATIONAL THERAPY 0 538 45. 00 46. 00 04600   SPEECH PATHOLOGY 0 195 46. 00 48. 00 04800   MEDICAL SUPPLIES CHARGED TO PATIENTS 0 5, 934 48. 00 49. 00 04900   DRUGS CHARGED TO PATIENTS 0 2, 2067 49. 00 51. 00 04900   DRUGS CHARGED TO PATIENTS 0 2, 2067 49. 00 51. 00 04900   SUPPORT SURFACES 0 0 0 0 51. 00 04900   SUPPORT SURFACES 0 0 0 0 51. 00 04900   OVERAPTION OF SUPPORT SURFACES 0 0 0 0 0 51. 00 07100   MBBULANCE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1				
43. 00 04300 0XYGEN (INHALATION) THERAPY 0 362 44. 00 04400 PHYSI CAL THERAPY 0 20, 204 45. 00 04500 0CCUPATI ONAL THERAPY 0 538 46. 00 04600 SPEECH PATHOLOGY 0 1955 46. 00 04600 SPEECH PATHOLOGY 0 1955 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5, 934 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 2, 067 51. 00 05100 SUPPORT SURFACES 0 0 0 0 51. 00  00100 DRUGS CHARGED TO PATIENTS 0 0 2, 067 51. 00 05100 SUPPORT SURFACES 0 0 0 0 51. 00  00100 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
44. 00   04400   PHYSICAL THERAPY   0   20,204   44. 00   45. 00   04500   0CCUPATI ONAL THERAPY   0   538   45. 00   04600   SPECH PATHOLOGY   0   195   46. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   5,934   48. 00   04900   DRUGS CHARGED TO PATIENTS   0   2,067   49. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0	42.00	04200 I NTRAVENOUS THERAPY	0	201		42. 00
45. 00	43.00	04300 OXYGEN (INHALATION) THERAPY	0			43.00
46. 00	44.00	04400 PHYSI CAL THERAPY	0	20, 204		44. 00
48. 00	45.00	04500 OCCUPATI ONAL THERAPY	0	538		45. 00
49. 00	46.00	04600 SPEECH PATHOLOGY	0	195		46. 00
51.00   05100   SUPPORT SURFACES   0   0   0   0	48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	5, 934		48. 00
OUTPATIENT SERVICE COST CENTERS	49.00	04900 DRUGS CHARGED TO PATIENTS	O	2, 067		49. 00
OUTPATIENT SERVICE COST CENTERS   O6200 FQHC	51.00	05100 SUPPORT SURFACES	o	o		51.00
62. 00   Office   Off				-,		
OTHER REI MBURSABLE COST CENTERS   O	62. 00					62, 00
70. 00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   71.00   71.00   71.00   73.00	02.00					02.00
71. 00	70 00		0	0		70.00
73. 00   07300   CMHC   0   0   0     SPECIAL PURPOSE COST CENTERS  89. 00   SUBTOTALS (sum of lines 1-84)   0   305, 814     NONREI MBURSABLE COST CENTERS  90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   91. 00   09100   BARBER & BEAUTY SHOP   0   8   91. 00 92. 00   09200   PHYSI CI ANS' PRI VATE OFFICES   0   0   0   93. 00   09300   NONPAI D WORKERS   0   0   0   94. 00   09400   PATI ENTS' LAUNDRY   0   0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   95. 00   09500   005				- 1		
SPECIAL PURPOSE COST CENTERS   89.00   SUBTOTALS (sum of lines 1-84)   0   305,814   89.00						l l
89. 00   SUBTOTALS (sum of lines 1-84)   0   305,814   89. 00	73.00		<u> </u>	<u> </u>		73.00
NONRE   MBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0	90 00			20E 014		90.00
90. 00   90.00   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   91.00   91.00   92.00   92.00   94.00   93.00   09400   PATIENTS' LAUNDRY   0   0   0   95.00   09500   OTHER NONREIMBURSABLE COST   0   0   0   95.00   0   0   95.00   0   0   0   0   0   0   0   0   0	69.00		J U	303, 614		09.00
91. 00   09100   BARBER & BEAUTY SHOP   0   8   91. 00   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   93. 00   94. 00   94. 00   95. 00   07500   OTHER NONREI MBURSABLE COST   0   0   0   0   95. 00   0   0   0   0   0   0   0   0   0	00.00					
92. 00     09200     PHYSI CI ANS' PRI VATE OFFI CES     0     0     92. 00       93. 00     09300     NONPAI D WORKERS     0     0     93. 00       94. 00     09400     PATI ENTS' LAUNDRY     0     0     94. 00       95. 00     09500     OTHER NONREI MBURSABLE COST     0     0     95. 00			1	- 1		
93. 00   09300   NONPAI D WORKERS   0 0 0 94.00   94.00   95. 00   09500   OTHER NONREI MBURSABLE COST   0 0 0 95.00   0 0 95.00   0 0 0   0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0   0 0   0 0   0 0   0 0   0 0   0 0   0   0 0   0			1	- 1		l l
94. 00   09400   PATI ENTS' LAUNDRY   0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   0   95. 00			0	-1		<b>I</b>
95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   95. 00			0	-1		
		1	0	-1		<b>I</b>
00 00			0	0		
	98. 00	1 1	0	0		98. 00
99.00   Negative Cost Centers   0   0   99.00	99. 00	Negative Cost Centers	0	O		99. 00
100. 00 TOTAL 0 305, 822 100. 00	100.0	D TOTAL	0	305, 822		100. 00

COST ALLOCATION - STATISTICAL BASIS Provider No.: 315101 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/19/2022 8: 20 am CAPI TAL RELATED COSTS Cost Center Description BLDGS & **EMPLOYEE** Reconciliation ADMINISTRATIVE **PLANT FIXTURES BENEFITS** OPERATION, & GENERAL (SQUARE (GROSS MAINT. & (ACCUM. FEET) SALARI ES) COST) REPAI RS (SQUARE FEET) 1.00 3.00 4.00 4A 5.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 25, 953 1.00 3.00 00300 EMPLOYEE BENEFITS 5, 708, 094 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 3, 374 333, 314 -1, 971, 639 9, 841, 554 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 654, 319 20.742 5.00 1,837 141, 927 5 00 6.00 00600 LAUNDRY & LINEN SERVICE 423 0 588, 290 423 6.00 00700 HOUSEKEEPI NG 0 89, 373 424 7.00 424 7.00 571, 243 00800 DI ETARY 1, 131, 122 2, 140 0 2, 140 8.00 8.00 0 9 00 00900 NURSING ADMINISTRATION 183 351, 630 472,050 183 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 33, 046 0 366, 946 10.00 0 0 11.00 01100 PHARMACY 0 0 36, 622 0 11.00 01300 SOCIAL SERVICE 0 124, 950 13.00 13.00 183 162, 324 183 15.00 01500 PATIENT ACTIVITIES 722 154, 992 0 220, 368 722 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 14, 700 3, 699, 133 0 5, 231, 088 14, 700 30.00 31.00 03100 NURSING FACILITY 0 0 31.00 33.00 03300 OTHER LONG TERM CARE 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 29, 920 40.00 0 0 04100 LABORATORY 0 C 0 5, 885 41.00 Λ 41.00 04200 I NTRAVENOUS THERAPY 0 0 49,873 42.00 42.00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 89, 501 43.00 0 44.00 04400 PHYSI CAL THERAPY 154, 521 0 212, 820 1, 460 44.00 1,460 45.00 04500 OCCUPATIONAL THERAPY 0 105, 235 0 133, 222 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 38, 103 0 48, 237 0 46.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 416 C 0 104, 631 48.00 416 04900 DRUGS CHARGED TO PATIENTS 0 49.00 49 00 91 C 213, 040 91 51.00 05100 SUPPORT SURFACES 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 06200 FQHC 62 00 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 71.00 0 73.00 07300 CMHC 0 73 00 Ω SPECIAL PURPOSE COST CENTERS 89.00 SUBTOTALS (sum of lines 1-84) 25, 953 5, 708, 094 -1, 971, 639 9, 839, 631 20, 742 89.00 NONREI MBURSABLE COST CENTERS 90 00 90 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91.00 09100 BARBER & BEAUTY SHOP 0 0 1, 923 0 91.00 09200 PHYSICIANS' PRIVATE OFFICES 0 0 92.00 92.00 0 0 09300 NONPALD WORKERS 0 0 93.00 93.00 0 0 0 0 94.00 09400 PATIENTS' LAUNDRY 0 C 0 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 0 95.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, 305, 822 1, 518, 079 1, 971, 639 785, 404 102. 00 Part I)

11. 783686

0. 265952

0.000000

0. 200338

0.004040

39.758

37. 865394 103. 00

1. 171054 105. 00

24, 290 104. 00

103.00

104.00

105.00

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Part II)

11)

Heal th	Fi nan	icial Systems	JEK HARIWYCK A	I CEDAR BROOK		In Lie	u of Form CMS-:	2540-10
COST A	LLOCA	TION - STATISTICAL BASIS		Provi der	No.: 315101	Peri od:	Worksheet B-1	
						From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 8:2	
		Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	
			LINEN SERVICE	(SQUARE	(PATI ENT	ADMI NI STRATI ON	SERVICES &	
			(PATI ENT	FEET)	DAYS)	(0.47) 5117	SUPPLY	
			DAYS)			(PATI ENT	(PATIENT	
			/ 00	7.00	0.00	DAYS)	DAYS)	
	CENED	AL CEDVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS - BLDGS & FIXTURES		I	I			1.00
3.00		EMPLOYEE BENEFITS						3.00
4.00	1	ADMINISTRATIVE & GENERAL						4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00		LAUNDRY & LINEN SERVICE	34, 416					6.00
7. 00		HOUSEKEEPING	34, 410	19, 895				7.00
8. 00		DIETARY	0			16		8.00
9. 00		NURSING ADMINISTRATION	0	183		0 34, 416		9.00
10. 00	1	CENTRAL SERVICES & SUPPLY	0	0	1	0 34,410	34, 416	
11. 00	1	PHARMACY	0		1	0 0	0	
13. 00	1	SOCIAL SERVICE	0	1	1	0 0	0	1
15. 00	1	PATIENT ACTIVITIES	0		1		0	
13.00		IENT ROUTINE SERVICE COST CENTERS	0	122		0		13.00
30. 00		SKILLED NURSING FACILITY	34, 416	14, 700	34, 4	16 34, 416	34, 416	30.00
31. 00	1	NURSING FACILITY	0 0 1, 110			0 0	01, 110	1
33. 00		OTHER LONG TERM CARE	0			0 0	0	1
33. 00		LARY SERVICE COST CENTERS			1	<u> </u>		33.00
40. 00		RADI OLOGY	0	0		0 0	0	40. 00
41. 00	1	LABORATORY	0			0 0	0	
42. 00	1	I NTRAVENOUS THERAPY	0			0 0	0	1
43. 00	1	OXYGEN (INHALATION) THERAPY	0	ĺ	1	o o	0	1
44. 00	1	PHYSI CAL THERAPY	0	1, 460	l .	0 0	0	1
45. 00	1	OCCUPATI ONAL THERAPY	0	0	1	0 0	0	1
46.00	1	SPEECH PATHOLOGY	0	0	,	0 0	0	1
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	416	,	0 0	0	1
49.00		DRUGS CHARGED TO PATIENTS	0	91		0 0	0	49. 00
51.00	05100	SUPPORT SURFACES	0	0	1	0 0	0	51.00
	OUTPA	TIENT SERVICE COST CENTERS	•		•	<u>.</u>		
62.00	06200	FQHC						62. 00
		REIMBURSABLE COST CENTERS						
70.00	1	HOME HEALTH AGENCY COST	0		1	0	0	
71. 00	1	AMBULANCE	0		l .	0	0	71. 00
73. 00	07300		0	0		0 0	0	73. 00
	SPECI.	AL PURPOSE COST CENTERS			1			
89. 00		SUBTOTALS (sum of lines 1-84)	34, 416	19, 895	34, 4	16 34, 416	34, 416	89. 00
		IMBURSABLE COST CENTERS	_	_	1			
90.00	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		1	0 0	0	
91. 00	1	BARBER & BEAUTY SHOP	0	1		0 0	0	91. 00
92. 00		PHYSICIANS' PRIVATE OFFICES	0	0	1	0 0	0	
93. 00		NONPAI D WORKERS	0	0	1	0 0	0	
94. 00	1	PATIENTS' LAUNDRY	0	0	1	0 0	0	94.00
95. 00	09500	OTHER NONREIMBURSABLE COST	0	0	1	0 0	0	95. 00
98. 00		Cross Foot Adjustments						98. 00
99.00		Negative Cost Centers	700 4::	100 5	4 .50 -			99.00
102.00	'	Cost to be allocated (per Wkst. B,	722, 164	123, 333	1, 452, 02	27 574, 683	440, 459	102.00
102.00		Part I)	20 002200	4 100107	42 1004	4/ 1/ /00105	12 700000	102 00
103.00 104.00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	20. 983380 7, 856		1		12. 798088	103.00
104.00	]	Part II)	1,000	3, 654	32, 9,	23 4, 331	1, 482	104.00

0. 228266

0. 294245

0. 956619

0. 125843

0. 043061 105. 00

Part II)

11)

Unit cost multiplier (Wkst. B, Part

105.00

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/19/2022 8:20 am

OTHER GENERAL SERVICE SERVICE DATE OF THE PROPERTY OF THE PROP	
Cost Contan Decemintion DUADMACY COCIAL CEDVICE DATIENT	
Cost Center Description   PHARMACY   SOCIAL SERVICE   PATIENT	
. PATIENT ACTIVITIES	
DAYS) (PATIENT (PATIENT	
DAYS) DAYS)	
11.00 13.00 15.00	
GENERAL SERVICE COST CENTERS	
1. 00 00100 CAP REL COSTS - BLDGS & FLXTURES	1, 00
3. 00 00300 EMPLOYEE BENEFITS	3.00
4. OO   00400  ADMI NI STRATI VE & GENERAL	4. 00
5. 00   00500 PLANT OPERATION, MAINT. & REPAIRS	5. 00
6. 00   00600   LAUNDRY & LINEN SERVICE	6. 00
7. 00   00700   HOUSEKEEPI NG	7.00
8. 00   00800 DI ETARY	8.00
	•
9. 00   00900   NURSI NG   ADMI NI STRATI ON	9. 00
10.00   01000   CENTRAL SERVICES & SUPPLY	10. 00
11. 00   01100   PHARMACY 34, 416	11. 00
13. 00   01300   SOCI AL   SERVI CE   0   34, 416	13. 00
15. 00   O1500   PATIENT ACTIVITIES   O   O   34, 416	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
30.00   03000   SKI LLED NURSI NG FACI LI TY   34,416   34,416   34,416	30. 00
31.00 03100 NURSING FACILITY 0 0 0	31. 00
33. 00   03300   0THER LONG TERM CARE   0   0   0	33.00
ANCILLARY SERVICE COST CENTERS	
40. 00 04000 RADI 0LOGY 0 0 0	40. 00
41. 00   04100   LABORATORY   0 0 0	41.00
42. 00   04200   I NTRAVENOUS THERAPY 0 0 0	42. 00
43. 00   04300   0XYGEN ( I NHALATI ON ) THERAPY   0   0   0	43. 00
44. 00   04400   PHYSI CAL THERAPY   0   0   0	44. 00
45. 00   04500   OCCUPATI ONAL THERAPY	45. 00
46. 00   04600  SPEECH PATHOLOGY	46. 00
48. 00   04800   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0 0 0	48. 00
49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   0	49. 00
51. 00   05100   SUPPORT SURFACES	51.00
	51.00
OUTPATIENT SERVICE COST CENTERS	(2.00
62. 00 06200 FQHC	62. 00
OTHER REIMBURSABLE COST CENTERS	
70. 00   07000   HOME   HEALTH   AGENCY COST   0   0   0	70. 00
71. 00   07100   AMBULANCE   0   0   0	71. 00
73. 00 07300 CMHC 0 0 0	73. 00
SPECIAL PURPOSE COST CENTERS	
89.00   SUBTOTALS (sum of lines 1-84)   34,416   34,416   34,416	89. 00
NONREI MBURSABLE COST CENTERS	
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0	90. 00
91. 00   09100   BARBER & BEAUTY SHOP   0   0   0	91.00
92. 00   09200   PHYSI CI ANS' PRI VATE OFFI CES 0 0 0	92. 00
93. 00   09300   NONPAI D WORKERS   0   0	93. 00
94. 00   09400   PATI ENTS' LAUNDRY 0 0 0	94.00
95. 00   09500 OTHER NONREIMBURSABLE COST 0 0 0	95. 00
98.00 Cross Foot Adjustments	98. 00
99. 00   Negative Cost Centers	99.00
102.00 Cost to be allocated (per Wkst. B, 43,959 202,907 296,331	102. 00
Part I)	102.00
	103. 00
104.00   Cost to be allocated (per Wkst. B, 148 3,080 10,456	104. 00
Part II)  105 00 Unit cost multiplier (What B Part 0 004200 0 000402 0 202012	105 00
105.00 Unit cost multiplier (Wkst. B, Part 0.004300 0.089493 0.303812	105. 00
	ı

Health Financial Systems JFK HARTWYCK AT CEI	DAR BROOK		In Lie	eu of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		No.: 315101 F	Peri od:	Worksheet C	
			rom 01/01/2021		
		1	o 12/31/2021	Date/Time Prep 5/19/2022 8: 20	
Cost Center Description		Total (from	Total Charges		U alli
cost center bescription		Wkst. B, Pt I,		di vi ded by	
		col . 18)		col. 2	
		1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS			<u>'</u>		
40. 00   04000   RADI OLOGY		35, 914	29, 920	1. 200334	40. 00
41. 00   04100   LABORATORY		7, 064	6, 976	1. 012615	41. 00
42. 00   04200   I NTRAVENOUS THERAPY		59, 864	49, 873	1. 200329	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY		107, 431	89, 501	1. 200333	43.00
44. 00 O4400 PHYSI CAL THERAPY		319, 790	318, 610	1. 003704	44. 00
45. 00   04500   OCCUPATI ONAL THERAPY		159, 911	341, 750	0. 467918	45. 00
46. 00   04600   SPEECH PATHOLOGY		57, 901	110, 175	0. 525537	46. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		143, 924	99, 729	1. 443151	48. 00
49.00 O4900 DRUGS CHARGED TO PATIENTS		259, 730	211, 968	1. 225326	49. 00
51. 00 05100 SUPPORT SURFACES		(	0	0.000000	51.00
OUTPAȚI ENT SERVI CE COST CENTERS			+		
62. 00   06200   FQHC					62. 00
71. 00   07100   AMBULANCE		(	0	0. 000000	71. 00
100. 00   Total		1, 151, 529	1, 258, 502		100. 00

Health Financial Systems	JFK HARTWYCK A	T CEDAR BROOK		In Lie	eu of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I	norod.
					Date/Time Pre 5/19/2022 8:2	o am
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pr	rogram Charges		Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Col umn 3) 1.00	2.00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	0.00	1. 00	0.00	
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	1. 200334	0		0 0	0	40. 00
41. 00  04100  LABORATORY	1. 012615			0	0	
42. 00   04200   I NTRAVENOUS THERAPY	1. 200329			0	0	
43.00 O4300 OXYGEN (INHALATION) THERAPY	1. 200333			0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 003704			94, 981	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 467918			0 44, 588	l	
46. 00 04600 SPEECH PATHOLOGY	0. 525537			0 6, 249	1	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 443151			0	0	1 .0.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 225326			0 75, 076	l	
51. 00 O5100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0. 000000	0		0 0	0	51. 00
62. 00 06200 FQHC						62.00
71. 00   07100   AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of lines 40 - 71)	0.000000	263, 080		0 220, 894		100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	V	203, 000	l '	220, 094	ı	1100.00
(.,	<i>J</i> .					

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

Health Financial Systems	JFK HARTWYCK A	T CEDAR BROOK		In Lie	eu of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/19/2022 8:2	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1, 00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C. column 3	line 49)	1. 225326	1.00
2.00 Program vacci ne charges (From your reco			t o, cordiiir o,	, 11110 17)	0	1
3.00   Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	0	3.00
E, Part I, line 18)	,					
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	(From Wkst. B,	Allied Health	Nursing &	Cost (From	& Allied	
	Part I, Col.	(From Wkst. B,	Allied Healt		Health Costs	
	18		Costs to Tota		for Pass	
		14)	Costs - Part		Through (Col.	
			(Col. 2 / Col		3 x Col. 4)	
	1.00	0.00	1)	4.00	F 00	
DART III CALCIII ATLONI OF DACC TURQUICU COCTO	1.00	2.00	3. 00	4. 00	5. 00	
PART III - CALCULATION OF PASS THROUGH COSTS ANCILLARY SERVICE COST CENTERS	FUR NURSTING &	ALLIED HEALTH				
40. 00   04000 RADI OLOGY	35, 914		0.00000	0	0	40.00
41. 00   04100   LABORATORY	7, 064	l .	0.00000		0	41.00
42. 00   04200   NTRAVENOUS THERAPY	59, 864		0.00000		0	42.00
43. 00   04300   0XYGEN (INHALATION) THERAPY	107, 431		0.00000		0	43.00
44. 00   04400   PHYSI CAL THERAPY	319, 790		0.00000		0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	159, 911	l .	0.00000		1	45. 00
46. 00 04600 SPEECH PATHOLOGY	57, 901		0. 00000			
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	143, 924	l .	0. 00000		Ö	
49. 00 04900 DRUGS CHARGED TO PATIENTS	259, 730	l .	0.00000			
51. 00   05100 SUPPORT SURFACES	0	ا	0.00000		Ö	
100.00 Total (Sum of Lines 40 - 52)	1, 151, 529	l o	1	220, 894	1	100.00

MPUTATION OF INPATIENT ROUT	INE COSTS	Provi der No.: 315101	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre	pare
		Title XVIII	Skilled Nursing Facility	5/19/2022 8: 2 PPS	<u>0 am</u>
			raciiity		
				1. 00	
PART I CALCULATION OF I	NPATIENT ROUTINE COSTS				4
INPATIENT DAYS  Inpatient days including	ag private room days			34, 416	1.
00 Private room days	ig private room days			34, 410	
	ng private room days applicable	e to the Program		1, 350	1
	vate room days applicable to			1, 330	
00 Total general inpatien		trie i regram		10, 659, 356	1
PRIVATE ROOM DIFFERENTI					Ī
OO General inpatient rout	ne service charges			14, 041, 715	6
OO General inpatient rout	ne service cost/charge ratio	(Line 5 divided by line 6)		0. 759121	7
DO Enter private room cha	rges from your records			0	8
, , ,	er diem charge (Private room ch	harges line 8 divided by private	room days, line	0.00	9
2)					
	m charges from your records		al Ia	0	
00 Average semi-private rosemi-private rosemi-private rosemi		vate room charges line 10, divide	d by	0. 00	11
, ,	, te room charge differential (Li	ine 9 minus line 11)		0.00	12
	te room cost differential (Line			0.00	
	erential adjustment (Line 2 time			0.00	
		e room cost differential (Line 5	minus line 14)	10, 659, 356	
PROGRAM INPATIENT ROUTI		· ·			1
00 Adjusted general inpat	ent service cost per diem (Lir	ne 15 divided by line 1)		309. 72	16
	e cost (Line 3 times line 16)			418, 122	
		orogram (line 4 times line 13)		0	
1 9 9	npatient routine service cost	` '		418, 122	
		service costs (From Wkst. B, Par	t II column 18,	276, 168	20
	31 for NF, or line 32 for ICF/I ed costs (Line 20 divided by I			8. 02	21
	d costs (Line 3 times line 21)	Title 1)		10, 827	
	ce cost (Line 19 minus line 2	22)		407, 295	
	eneficiaries for excess costs	•		0	
		the cost limitation (Line 23 mi	nus line 24)	407, 295	
00 Enter the per diem lim					26
00 Inpatient routine servi	ce cost limitation (Line 3 time	mes the per diem limitation line	26) (1)		27
00 Reimbursable inpatient	routine service costs (Line 22	2 plus the lesser of line 25 or	line 27)		28
• •	E, Part II, line 4) (See instr		ļ		
Lines 26 and 27 are not a	pplicable for title XVIII, but	may be used for title V and or t	itle XIX		
DADT II CALCIII ATLON OF	INDATIENT NUDCING O ALLIED UEA	VITH COSTS FOR DRS DASS TURQUOL		1. 00	
OO Total SNF inpatient da		ALTH COSTS FOR PPS PASS-THROUGH	T T	34, 416	1
00   Program inpatient days	,			1, 350	
		ns)(Do not complete for titles V	or XLX)	1, 350	1
	n ratio. (line 2 divided by lin		οι <i>Λ</i> ι <i>Λ</i> )	0. 039226	
o a ai i i oa iloai ti		·= ·/		0.037220	

Health Financial Systems	JFK HARTWYCK AT CED	AR BROOK	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provi der No.: 315101	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 5/19/2022 8: 20 am
		Title XVIII	Skilled Nursing	PPS

		litle XVIII	Skilled Nursing Facility	PPS	
		1	rudiffity		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT	<u> </u>		
1.00	Inpatient PPS amount (See Instructions)			868, 177	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			868, 177	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			137, 456	5.00
6.00	Allowable bad debts (From your records)			39, 964	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		15, 863	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			25, 977	8.00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			756, 698	11.00
12.00	Interim payments (See instructions)			761, 627	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			0	14. 99
15.00	Balance due provider/program (see Instructions)			-4, 929	15.00
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - T	ITLE XVIII ONLY		
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	Interim payments (See instructions)			0	26.00
27. 00	Tentati ve adjustment			0	27.00
28. 00	Other Adjustments (See instructions) Specify			0	28.00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
	Balance due provider/program (see instructions)			0	29.00
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2, s	ection 115.2	0	30. 00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315101 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Preg

				Facility		
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		730, 721		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	00 (0) (0001	00.00/			
3. 01	ADJUSTMENTS TO PROVIDER	08/26/2021	30, 906		0	3. 01
3.02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3. 05
0.50	Provi der to Program					0.50
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0 00 00 (		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		30, 906		0	3. 99
4. 00	- 3.98) Total interim payments (sum of lines 1, 2, and 3.99)		761, 627		0	4. 00
4.00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		701,027		ا	4.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		o	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)		_		_	
6. 01	PROGRAM TO PROVI DER		0		0	6. 01
6. 02	PROVI DER TO PROGRAM		4, 929		0	6. 02
7.00	Total Medicare program liability (see instructions)		756, 698	N	0	7. 00
			Contract	or name	Contractor	
			1. (	00	Number 2.00	
8 00	Name of Contractor		1.	00	2.00	8. 00
	Inalle of Contractor				۱	0.00

<sup>(1)</sup> 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 only)

Provi der No.: 315101 | Peri od: From 01/01/20

| Period: | Worksheet G | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/19/2022 8: 20 am

oni y)			0 : 6:	12, 01, 2021	5/19/2022 8: 2	0 am
		General Fund	Specific E Purpose Fund	ndowment Fund	Plant Fund	
	Assets	1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					1
1. 00	Cash on hand and in banks	178, 930	0	0	0	
2.00	Temporary investments	0	0	0	0	
3.00	Notes recei vable	0	0	0	0	1
4. 00 5. 00	Accounts receivable Other receivables	2, 692, 598	0	O O	0	
6. 00	Less: allowances for uncollectible notes and accounts	-28, 288 -1, 117, 458		0	0	
0.00	recei vabl e	1, 117, 430		٩	O	0.0
7. 00	Inventory	10, 455	0	О	0	7.0
8. 00	Prepai d expenses	8, 972	0	O	0	8. 0
9. 00	Other current assets	0	0	0	0	
10. 00	Due from other funds	0	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 745, 209	0	0	0	11.0
12. 00	FI XED ASSETS Land	1, 580, 000	O	ol	0	12. 0
13. 00	Land improvements	1, 580, 000	0	ol	0	
14. 00	Less: Accumulated depreciation	0	o o	o	0	
15. 00	Bui I di ngs	1, 761, 006	O	ō	0	1
16. 00	Less Accumulated depreciation	-1, 150, 206	0	O	0	16.0
17. 00	Leasehold improvements	0	0	0	0	
18. 00	Less: Accumulated Amortization	0	0	0	0	
19. 00	Fixed equipment	90, 630	1	0	0	1
20.00	Less: Accumulated depreciation	-9, 441	0	0	0	
21. 00	Automobiles and trucks	0	0	0	0	
22. 00 23. 00	Less: Accumulated depreciation Major movable equipment	156, 111	0	U O	0	
24. 00	Less: Accumulated depreciation	-78, 042	0	0	0	
25. 00	Mi nor equi pment - Depreci abl e	-70,042	0	0	0	
26. 00	Mi nor equipment nondepreciable	0	Ö	o	0	
27. 00	Other fixed assets	0	0	O	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	2, 350, 058	0	O	0	28. 0
	OTHER ASSETS					
29. 00	Investments	0	0	0	0	
30. 00	Deposits on Leases	0	0	0	0	
31.00	Due from owners/officers	0	0	0	0	
32. 00 33. 00	Other assets TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	0	0	0	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	4, 095, 267	0	0	0	
0 11 00	Liabilities and Fund Balances	1,070,207	<u> </u>	<u> </u>		1
	CURRENT LI ABI LI TI ES					]
35. 00	Accounts payable	520, 774	0	0	0	
36. 00	Salaries, wages, and fees payable	0	0	0	0	1
37. 00	Payroll taxes payable	0	0	0	0	
38. 00 39. 00	Notes & Loans payable (Short term) Deferred income	0	0	0	0	
40. 00	Accel erated payments		U	U	U	40.0
41. 00	Due to other funds	752, 690	0	0	0	
42. 00	Other current liabilities	340, 472	1	o	0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 613, 936	1	o	0	
	LONG TERM LIABILITIES					
44. 00	Mortgage payable	0	0	0	0	44.0
45. 00	Notes payable	0	0	0	0	
46. 00	Unsecured Loans	0	0	0	0	
47. 00	Loans from owners:	0	0	0	0	
48. 00	Other long term liabilities	170 020	0	0	0	
49. 00 50. 00	RESIDENT PNA TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	178, 930 178, 930	1	U O	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	1, 792, 866		0	0	
01.00	CAPITAL ACCOUNTS	1,772,000	<u> </u>	<u> </u>		1 01.0
52. 00	General fund balance	2, 302, 401				52.0
53. 00	Specific purpose fund		0			53.0
54. 00	Donor created - endowment fund balance - restricted			o		54. C
55. 00	Donor created - endowment fund balance - unrestricted			O		55.0
56. 00	Governing body created - endowment fund balance			0		56.0
	Plant fund balance - invested in plant				0	
		1	ı		0	58.0
	Plant fund balance - reserve for plant improvement,					
58. 00	replacement, and expansion	2 202 401			0	50 0
57. 00 58. 00 59. 00 60. 00		2, 302, 401 4, 095, 267	0	0	0	

					0 12/31/2021	5/19/2022 8: 2	
		General	Fund	Special Pu	irpose Fund	Endowment Fund	o aiii
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		2, 773, 787		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-471, 386				2. 00
3.00	Total (sum of line 1 and line 2)		2, 302, 401		0		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00		0		C	)	0	5. 00
6.00		0		C		0	6. 00
7. 00		0		C		0	7. 00
8.00		0		C		0	8. 00
9.00	T-+-1	0		C	)	0	9.00
10.00	Total additions (sum of line 5 - 9)		2 202 401		0		10.00
11.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments)		2, 302, 401				11.00
12. 00 13. 00	Deductions (debit adjustments)	0		c		0	12. 00 13. 00
14. 00						0	14.00
15. 00						0	15. 00
16. 00						0	16.00
17. 00		l ő		C		0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		o	_	0		18. 00
19.00	Fund balance at end of period per balance		2, 302, 401		0		19.00
	sheet (Line 11 - line 18)						
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0.00	7.00	8.00			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)	0		(	1		3. 00
4.00	Additions (credit adjustments)						4. 00
5. 00			o				5. 00
6.00			O				6. 00
7.00			o				7. 00
8.00			o				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		C	)		11. 00
12. 00	Deductions (debit adjustments)						12. 00
13. 00			0				13. 00
14. 00			0				14. 00
15.00			0				15.00
16.00			0				16.00
17. 00	Total deductions (our of 1: 12 17)		o				17.00
18. 00 19. 00	Total deductions (sum of lines 13 - 17)	0		C			18. 00 19. 00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)						19.00
	Isheer (Fille II - IIHe 10)	1	l	l	I		I

Hoal th	Financial Systems JFK HARTWYCK AT CED	ND DDOOK		In Lie	eu of Form CMS-:	2540 10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES		No.: 315101	Peri od: From 01/01/2021 To 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/19/2022 8:2	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		
1. 00	SKILLED NURSING FACILITY		14, 041, 7		14, 041, 715	1. 00
2.00	NURSING FACILITY			0	0	
3.00	ICF/IID			0	0	1 0.00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		14, 041, 7	15	14, 041, 715	5. 00
	All Other Care Services		1		Г	
6. 00	ANCI LLARY SERVI CES		967, 00	51 0	967, 061	6. 00
7. 00	CLINIC			0	0	7. 00
8. 00	HOME HEALTH AGENCY COST			0	0	
9. 00	AMBULANCE			0	0	
10. 00	RURAL HEALTH CLINIC			0	0	10. 00
10. 10	FQHC			0	0	1
11. 00	CMHC			0	0	
12.00	HOSPI CE			0	0	12. 00
13.00	OTHER (SPECIFY)			0	0	13. 00
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	to	15, 008, 7	76 0	15, 008, 776	14. 00
	Worksheet G-3, Line 1)					
	Cost Center Description					
				1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				12, 162, 380	1
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	0.00
9.00	Deduct (Specify)			0		9. 00
10.00				0		10. 00
11.00				0		11. 00
12.00				0		12. 00
13.00				0		13.00
14 00	Total Doductions (Sum of Lines 0 12)				Ι	14 00

13. 00 14. 00 0

12, 162, 380 15. 00

15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

13.00 14.00 Total Deductions (Sum of lines 9 - 13)

Heal th	Financial Systems JFK HARTWYCK AT CEI	DAR BROOK	In Lie	u of Form CMS-2	2540-10
STATE	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315101	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Prep 5/19/2022 8: 20	oared: O am
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1	4)		15, 008, 776	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	3		4, 355, 203	2.00
3.00	Net patient revenues (Line 1 minus line 2)			10, 653, 573	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		12, 162, 380	4.00
5.00	Net income from service to patients (Line 3 minus 4)			-1, 508, 807	5. 00
	Other income:				ı

		07 177 2022 0. 20	<u> </u>
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	15, 008, 776	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	4, 355, 203	2. 00
3.00	Net patient revenues (Line 1 minus line 2)	10, 653, 573	
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	12, 162, 380	
5.00	Net income from service to patients (Line 3 minus 4)	-1, 508, 807	5. 00
	Other income:		l
6.00	Contributions, donations, bequests, etc	0	6. 00
7.00	Income from investments	2, 409	7. 00
8.00	Revenues from communications ( Telephone and Internet service)	0	8. 00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase di scounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
12.00	Parking lot receipts	0	12. 00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17.00	Revenue from sale of drugs to other than patients	0	17. 00
18.00	Revenue from sale of medical records and abstracts	0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20. 00
21.00	Rental of vending machines	0	21. 00
22. 00	Rental of skilled nursing space	0	22. 00
23.00	Governmental appropriations	0	23. 00
24.00	OTHER REVENUE	133, 000	24. 00
24. 50	COVI D-19 PHE Funding	902, 012	24. 50
25.00	Total other income (Sum of lines 6 - 24)	1, 037, 421	25. 00
26.00	Total (Line 5 plus line 25)	-471, 386	26. 00
27.00	Other expenses (specify)	0	27. 00
28. 00		o	28. 00
29. 00		0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
	Net income (or loss) for the period (Line 26 minus line 30)	-471, 386	