Heal th Financia	I Systems CONTINUI	NG CARE AT LA	NTERN HILL	In Lie	u of Form CMS-2540-10
	required by law (42 USC 1395g; 42 CFR 413.) since the beginning of the cost reporting p				FORM APPROVED OMB NO. 0938-0463
	since the beginning of the cost reporting p	errou berng u	eenied over payments (42	. 030 13939).	Expi res: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA PORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 9/7/2022 1:57 pm
PART I - COST F	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost rep	port		Date:	Time:
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report en	ter the numbe	r of times the provide	r resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes o	r leave blank for no.		
Contractor	4.[2]Cost Report Status	6. Contractor	No. 12	001	
use only	(1) As Submitted	7.[N]Firs	t Cost Report for this	Provider CCN	
	Settled without audit	8.[N]Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:	. 09/23/20	022	
	(4) Reopened	10.[0] f	ine 4, column 1 is "4"	Enter number of	times reopened
	(5) Amended		r Vendor Code		
	5. Date Received: <u>06/02/2022</u>		care Utilization. Enterno utilization.	er "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 CONTINUING CARE AT LANTERN HILL (315523) 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	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	Signatory Title			3
4	Date			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	0	0	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	0	0	0	100.00

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

	Financial Systems CC D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA	ITY HEALTH	CARE	Provider No	.: 315523	Period: From 01/01, To 12/31,		Workshe Part I Date/Ti 9/7/202	me Pre	parec
	1.00	2.		-	3.00					
~~	Skilled Nursing Facility and Skilled Nursing		Complex Add	iress:						
	Street: 537 MOUNTAIN AVENUE	PO Box:		7: - 0 07	074					1.0
	City: NEW PROVIDENCE	State: NJ	25004	Zip Code: 07						2.0
	County: UNI ON	CBSA Code:	35084	Urban/Rural	: 0					3.0
01		CBSA Code:	Compon	ent Name	Provi der	Date	Daym	ent Syste	om (D	3. (
			compone	ent Name	CCN	Certified	Faying	0, or N		
					CON	Certified	V		, XI X	1
		-	1	00	2.00	3.00	4.00		6.00	<u> </u>
	SNF and SNF-Based Component Identification:			00	2.00	3.00	1 4.00	1 0.00	0.00	-
	SNF	C	ONTI NUI NG	CARE AT	315523	07/21/2017	N	Р	N	4.
			ANTERN HIL							
0	Nursing Facility					1				5.
0	ICF/IID					1				6.
0	SNF-Based HHA						1			7.
0	SNF-Based RHC						1			8.
	SNF-Based FQHC						1			9.
	SNF-Based CMHC						1			10.
	SNF-Based OLTC									11.
	SNF-Based HOSPICE									12.
	SNF-Based CORF									13.
						From		To:		
						1.00		2.0		1
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		14.
	Type of Control (See Instructions)						2			15.
								Y/I	N	
								1.0	0	1
	Type of Freestanding Skilled Nursing Facilit	V							-	
00	Is this a distinct part skilled nursing faci		eets the r	eaui rements	set forth	in 42 CFR		N		16.
	section 483.5?							i i		
00	Is this a composite distinct part skilled nu	rsing facil	ity that m	eets the re	auirements	set forth	in	N		17.
	42 CFR section 483.5?	i or ng i dor i	i tj that h		qui i omorreo	00000000				
00	Are there any costs included in Worksheet A	that result	ed from tr	ansactions	with relat	ed		Y		18.
	organizations as defined in CMS Pub. 15-1, c									
	Miscellaneous Cost Reporting Information		2							1
	If this is a low Medicare utilization cost r	eport, indi	cate with	a "Y", for	ves, or "N	" for no.		N		19.
	If line 19 is yes, does this cost report mee						е	N N		19.
	utilization cost report, indicate with a "Y"				5					
	Depreciation - Enter the amount of depreciat				e method ir	ndicated on	Li nes	20 - 22		1
00	Straight Line								97, 371	1 20.
00	Declining Balance							i i	C	21.
00	Sum of the Year's Digits							i i	C	22.
	Sum of line 20 through 22								97, 371	1 23.
	If depreciation is funded, enter the balanc	e as of the	end of th	e period.					Ċ	24.
	Were there any disposal of capital assets du				(Y/N)			N		25.
	Was accelerated depreciation claimed on any					portina per	i od?	N		26.
	(Y/N)			51		J J J J		i i		
00	Did you cease to participate in the Medicare	program at	end of th	e period to	which thi	s cost repo	rt	N		27.
	applies? (Y/N)			•		·				
00	Was there a substantial decrease in health i	nsurance pr	oportion c	f allowable	e cost from	prior cost		N		28.
	reports? (Y/N)							Ĺ		
								APart B		
) 2.00		
	If this facility contains a public or non-pu									1
	of the lower of the costs or charges enter "	Y" for each	n component	and type o	of service	that qualif	ies f	or the		1
	exemption.									4
	Skilled Nursing Facility						N	N		29.
	Nursing Facility								Ν	30.
	ICF/IID									31.
	SNF-Based HHA						N	N		32.
	SNF-Based RHC							N		33.
	SNF-Based FQHC									34.
	SNF-Based CMHC							N		35.
00	SNF-Based OLTC									36.
						Y/N				
						1.00		2.0	0	
	Is the skilled nursing facility located in a	state that	certifies	the provid	ler as a SN	F N				37.
00	regardless of the level of care given for Ti							l .		
00			? (Y/N)	. ,		N		l I		38.
	Are you legally-required to carry malpractic							í.		39.
00	Are you legally-required to carry malpractic is the malpractice a "claims-made" or "occur	rence" poli	cy? If the	policy is				ļ.		07.
00				policyis						57.
00	Is the malpractice a "claims-made" or "occur			policy is	Premiums	Paid Los	ses !	Selflns	urance	
00	Is the malpractice a "claims-made" or "occur				Premiums 1.00	Paid Los 2.00		Selfins 3.0		

Health Financial Systems CONTINUING CARE AT LANTERN HILL In Lieu of Form CMS	-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315523 Period: Worksheet S-	2
COMPLEX INDENTIFICATION DATA From 01/01/2021 Part I To 12/31/2021 Date/Time Pr	oparod
977/2021 1:5	
Y/N	
1.00	
42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost N	42.00
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 defined in CMS Pub. 15-1, Chapter 10? Y	43.00
44.00 If line 43 is yes, enter the home office chain number and enter the name and address of the home H57210	44.00
office on Lines 45, 46 and 47.	
1.00 2.00 3.00	
If this facility is part of a chain organization, enter the name and address of the home office on the lines	
bel ow.	
45.00 Name: ERICKSON LIVING MANAGEMENT Contractor's Name: NOVITAS Contractor's Number: 12001	45.00
46.00 Street: 701 MAIDEN CHOICE LANE PO Box:	46.00
47.00 City: CATONSVILLE State: MD Zip Code: 21228	47.00

	I Financial Systems CO ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT OUESTIONNALRE	<u>NTINUING CARE AT LA</u> TY HEALTH CARE		No.: 315523	Period: From 01/01/2021	worksheet S- Part II	
					To 12/31/2021	Date/Time Pr	
					Y/N	9/7/2022 1:5 Date	/ pm
					1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	1, "Y" fo	r Yes or "N"	for No. For all	the date	
00	Has the provider changed ownership immediatel	v prior to the bea	innina of	the cost	N		1 1.
	reporting period? If column 1 is "Y", enter t	the date of the char	nge in col	umn 2. (see			
	linstructions)			Y/N	Date	V/I	
				1.00	2.00	3.00	
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of			Ν			2.
	3, "V" for voluntary or "I" for involuntary.						
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or the relationships? (see instructions)	, chain home office d to the provider of , or members of the	es, drug r its e board	Y			3.
		· · · · ·		Y/N	Туре	Date	
				1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepa	ared 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 complet available in column 3. (see instructions) If						
00	Are the cost report total expenses and total			Ν			5.
	those on the filed financial statements? If o	column 1 is "Y", sul	omi t				
	reconciliation.				Y/N	Legal Oper.	
					1.00	2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	rad 2 (Y/N) Colump 2	le the	providor the	N	N	6
50	legal operator of the program? (Y/N)	. ,		provider the	IN IN		0.
00 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin	ng the cost reportio		for Nursing	N N		8
	School and/or Allied Health Program? (Y/N) se	ee Instructions.				Y/N	
						1.00	
00	Bad Debts Is the provider seeking reimbursement for bad	d debts? (V/N) see i	Instructio	ns		N	9
. 00	If line 9 is "Y", did the provider's bad deb				st reporting	N	10
00	period? If "Y", submit copy.					N	11
. 00	If line 9 is "Y", are patient deductibles and Bed Complement	azor coinsurance wai	ved? IT	Y, See Instr	ructions.	N	11
. 00	Have total beds available changed from prior	cost reporting peri	iod?lf"Y			N	12.
		Descriptio	n	Pa	art A Date	Part B Y/N	-
		0		1.00	2.00	3.00	+
	PS&R Data	ľ			- * - 1	I	
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			Ν		N	13
	prepare this cost report in cols. 2 and						
~~	4. (see Instructions.)				04/40/0000		
. 00	Was the cost report prepared using the PS&R for total and the provider's records for			Y	04/12/2022	Y	14
	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						
. 00	If line 13 or 14 is "Y", were adjustments			Ν		N	15.
	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",						
00	see Instructions.			NI		NI	1/
. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for			Ν		N	16.
	corrections of other PS&R Report						
00	information? If yes, see instructions.			NI		N	17
. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?			Ν		N	17.
	Describe the other adjustments:						
3. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.			Ν		N	18

Health Financial Systems C	ONTINUING CARE AT LA	ANTERN HILL	In Lie	In Lieu of Form CMS-2540-10			
SKILLED NURSING FACILITY AND SKILLED NURSING FACIL	ITY HEALTH CARE	Provider No.: 315523	Peri od:	Worksheet S-2			
COMPLEX REIMBURSEMENT QUESTIONNAIRE			From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	pared:		
				9/7/2022 1:57	pm		
		1.00	2.	00			
Cost Report Preparer Contact Information							
19.00 Enter the first name, last name and the titl	e/position STAC	CI	HENDERSON		19.00		
held by the cost report preparer in columns	1, 2, and 3,						
respecti vel y.							
20.00 Enter the employer/company name of the cost	report ERIC	CKSON LIVING MANAGEMENT			20.00		
preparer.							
21.00 Enter the telephone number and email address		-402-2347	STACI . HENDERSO	N@ERI CKSON. COM	21.00		
report preparer in columns 1 and 2, respecti	vel y.						

Heal th	Financial Systems CO	NTINUING CARE AT	T LANTERN HILL	In Lie	u of Form CMS-:	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No. : 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 9/7/2022 1:57	pared:
		Part B Date				
		4.00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)					13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	04/12/2022				14. 00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
			3.00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 7 respectively.		EIMBURSEMENT MANAGER			19. 00
20.00	Enter the employer/company name of the cost r	report				20. 00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

Heal th	Financial Systems	CONTINUING CARE AT L	ANTERN HILL	In Lieu	u of Form CMS-:	2540-10
VOLUNT	ARY CONTACT INFORMATION		Provider No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part V Date/Time Pre 9/7/2022 1:57	pared:
				1.0	20	
	Cost Report Preparer Contact Information					
1.00	First Name					1.00
2.00	Last Name					2.00
3.00	Title					3.00
4.00	Employer					4.00
5.00	Phone Number					5.00
6.00	E-mail Address					6.00
7.00	Department					7.00
8.00	Mailing Address 1					8.00
9.00	Mailing Address 2					9.00
10.00	City					10.00
11.00	State					11.00
12.00	Zip					12.00
	Officer or Administrator of Provider Conta	act Information				
13.00	First Name			Staci		13.00
14.00	Last Name			Henderson		14.00
15.00	Title					15.00
16.00	Employer					16.00
17.00	Phone Number			4104022347		17.00
18.00	E-mail Address			Staci.Hendersor	n@erickson.com	18.00
19.00	Department					19.00
20.00	Mailing Address 1			Dept: Central A	Accounting	20.00
21.00	Mailing Address 2					21.00
22.00	City			Baltimore		22.00
23.00	State				MD	
24.00	Zтр			21228		24.00

KILLI	Financial Systems ED NURSING FACILITY AND SKILLED NURSIN EX STATISTICAL DATA	CONTINUING CARE A IG FACILITY HEALTH CARE		No.: 315523	Period: From 01/01/2021 To 12/31/2021		pared:
				In	patient Days/Vis		
	Component	Number of Beds	Bed Days Avai I abl e	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
. 00	SKILLED NURSING FACILITY	40	14, 600		0 2, 263	0	1.00
. 00	NURSING FACILITY	0	0		0	0	2.00
. 00	ICF/IID						3.00
. 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care		0		0 0	0	4.00 5.00
. 00	SNF-Based CMHC	0	0				6.0
. 00	HOSPICE						7.0
. 00	Total (Sum of lines 1-7)	40	14, 600		0 2, 263	0	8.0
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	component	6.00	7.00	8.00	9.00	10.00	
. 00	SKILLED NURSING FACILITY	10, 130	12, 393		0 90		1.00
. 00	NURSING FACILITY	0	0		0	0	2.0
. 00	ICF/IID						3.0
. 00	HOME HEALTH AGENCY COST	0	0				4.0
. 00	Other Long Term Care SNF-Based CMHC	0	0				5.0
. 00 . 00	HOSPI CE						6.0 7.0
. 00	Total (Sum of lines 1-7)	10, 130	12, 393		0 90	0	
		Di scha		Ave	erage Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	component	11.00	12.00	13.00	14.00	15.00	
. 00	SKILLED NURSING FACILITY	79	169	0.0			1. 0
. 00	NURSING FACILITY	0	0	0.0	0	0.00	2.0
. 00	ICF/IID						3.0
. 00	HOME HEALTH AGENCY COST		0				4.0
. 00 . 00	Other Long Term Care SNF-Based CMHC	0	0				5.0 6.0
. 00	HOSPICE						7.0
. 00	Total (Sum of lines 1-7)	79	169	0.0	0 25.14	0.00	8.0
		Average Length		Admi	ssi ons		
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
	component	16.00	17.00	18.00	19.00	20.00	
. 00	SKILLED NURSING FACILITY	73. 33	0				1. 0
. 00	NURSING FACILITY	0.00	0		0	0	2. 0
. 00							3.0
. 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care	0.00				o	4.0 5.0
. 00	SNF-Based CMHC	0.00				0	5.0 6.0
. 00	HOSPI CE						7.0
. 00	Total (Sum of lines 1-7)	73. 33	0	10	4 0	65	8.0
		Admissions	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d	_		
	Component	IUtai	Payrol I	Workers			
		21.00	22.00	23.00			
. 00	SKILLED NURSING FACILITY	169	52.40				1.0
. 00	NURSING FACILITY	0	0.00	0.0	0		2.0
			0.00				3.0
	HOME HEALTH AGENCY COST		0.00				4.0 5.0
. 00							
. 00 . 00 . 00	Other Long Term Care	0	0.00	0.0			
. 00	SNF-Based CMHC HOSPICE	0	0.00	0.0			6.0 7.0

		UNTINUTING CARE /	AT LANTERN HILL			u of Form CMS-2	
SNF WF	IGE INDEX INFORMATION		Provider		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 9/7/2022 1:57	pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART I I – DI RECT SALARI ES						
	SALARI ES		1	1			
1.00	Total salaries (See Instructions)	11, 458, 865	0	11, 458, 86			
2.00	Physician salaries-Part A	0	0		0.00		
3.00	Physician salaries-Part B	0	0		0 0.00		
4.00	Home office personnel	0	0		0 0.00		
5.00	Sum of lines 2 through 4	0	0	11 150 01	0 0.00		
5.00	Revised wages (line 1 minus line 5)	11, 458, 865	0	11, 458, 86			6.0
7.00	Other Long Term Care	0	0		0 0.00		
3.00	HOME HEALTH AGENCY COST	0	0		0 0.00	0.00	
9.00 10.00	HOSPI CE						9. 0 10. 0
11.00	Other excluded areas	5, 425, 171	0	5, 425, 17	1 252, 963. 39	21.45	
12.00	Subtotal Excluded salary (Sum of lines 7	5, 425, 171		5, 425, 17			
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	6, 033, 694	0	6, 033, 69	4 191, 918. 76	31.44	13.0
	12) OTHER WAGES & RELATED COSTS						-
14.00	Contract Labor: Patient Related & Mgmt	0	0	1	0 0.00	0.00	1 14. C
14.00	Contract Labor: Physician services-Part A	0	0		0.00		
16.00	Home office salaries & wage related costs	0	0		0.00		
10.00	WAGE-RELATED COSTS	0	<u> </u>		0.00	0.00	1 10.0
17.00	Wage-related costs core (See Part IV)	3, 556, 634	0	3, 556, 63	4		17.0
8.00	Wage-related costs other (See Part IV)	0	Ö		0		18.0
19.00	Wage related costs (excluded units)	1, 904, 432	0	1, 904, 43	2		19.0
20.00	Physician Part A - WRC	0	0		о		20.0
21.00	Physician Part B - WRC	0	0		o		21.0
22.00	Total Adjusted Wage Related cost (see	1, 652, 202	0	1, 652, 20	2		22.0
	instructions)						

Heal th	Financial Systems	CONTINUING CARE	AT LANTERN HILL	-	In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2021 To 12/31/2021		narod
					10 12/31/2021	9/7/2022 1:57	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES				-		
1.00	Employee Benefits	367,664	0	367, 664	4 9, 400. 77	39.11	1.00
2.00	Administrative & General	1, 333, 700	0	1, 333, 700	29, 439. 51	45.30	2.00
3.00	Plant Operation, Maintenance & Repairs	713, 308	0	713, 308	32, 135. 75	22.20	3.00
4.00	Laundry & Linen Service	0	0	(0.00	0.00	4.00
5.00	Housekeepi ng	0	0	(0.00	0.00	5.00
6.00	Dietary	191, 601	0	191, 60 ⁻	1 3, 439. 97	55.70	6.00
7.00	Nursing Administration	0	0	(0.00	0.00	7.00
8.00	Central Services and Supply	0	0	(0.00	0.00	8.00
9.00	Pharmacy	0	0	(0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(0.00	0.00	10.00
11.00	Social Service	0	0		0.00	0.00	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	397, 757	0	397, 75	7 15, 719. 68	25.30	13.00
14.00	Total (sum lines 1 thru 13)	3,004,030	0	3, 004, 030	90, 135. 68	33.33	14.00

VF WA	GE RELATED COSTS	Provi der No.: 315523		Worksheet S-3	
			From 01/01/2021	Part IV	
			To 12/31/2021	Date/Time Pre 9/7/2022 1:57	pare
				Amount	-
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				-
	RETI REMENT COST				
00	401K Employer Contributions			0	1 .
00	Tax Sheltered Annuity (TSA) Employer Cont			0	
00	Qualified and Non-Qualified Pension Plan	Cost		183, 309	
00	Prior Year Pension Service Cost			0	4
	PLAN ADMINISTRATIVE COSTS (Paid to Extern	al Organization)		-	
00	401K/TSA Plan Administration fees			0	
00	Legal /Accounting/Management Fees-Pension			0	-
00	Employee Managed Care Program Administrat	on Fees		0	7
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funde	d)		1, 251, 655	
00	Prescription Drug Plan			0	
	Dental, Hearing and Vision Plan			0	
	Life Insurance (If employee is owner or b			0	
	Accident Insurance (If employee is owner			0	1
	Disability Insurance (If employee is owne			0	
	Long-Term Care Insurance (If employee is	owner or beneficiary)		0	1
	Workers' Compensation Insurance			287, 346	
6.00		year, not the extraordinary accrual requir	ed by FASB 106.	0	16
	Non cumulative portion) TAXES				
7.00	FICA-Employers Portion Only			824, 255	1 17
	Medicare Taxes - Employers Portion Only			0	
	Unemployment Insurance			825, 086	
	State or Federal Unemployment Taxes			184, 983	
	OTHER				
. 00	Executive Deferred Compensation			0	21
	Day Care Cost and Allowances			0	
	Tuition Reimbursement			0	23
. 00	Total Wage Related cost (Sum of lines 1 -	23)		3, 556, 634	24
				Amount	
				Reported	
				1.00	
	Part B - Other than Core Related Cost				

SNF RE	PORTING OF DIRECT CARE EXPENDITURES		Provi der	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet S-3 Part V Date/Time Pre 9/7/2022 1:57	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)		Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	575, 317	(575, 317		50.48	
2.00	Licensed Practical Nurses (LPNs)	710, 626	(D 710, 626		39.77	
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1, 011, 814	(D 1, 011, 814	44, 836. 10	22.57	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2, 297, 757	(2, 297, 757		31.01	4.00
5.00	Physical Therapists	0		o (c	0.00	0.00	
6.00	Physical Therapy Assistants	0		o (0.00	
7.00	Physical Therapy Aides	0		o (0.00	0.00	
8.00	Occupational Therapists	0		0 0			
9.00	Occupational Therapy Assistants	0		o (0.00	
10.00	Occupational Therapy Aides	0		0 0	0.00	0.00	
11.00	Speech Therapists	0		0 0		0.00	
	Respiratory Therapists	0		0 0			
13.00	Other Medical Staff	0	(0 (0.00	0.00	13.00
	Contract Labor						-
4.4.00	Nursing Occupations	0.7/5		0.7/		07.00	1 4 4 4 4 4
	Registered Nurses (RNs)	2, 765		2, 765			
15.00 16.00	Licensed Practical Nurses (LPNs) Certified Nursing Assistant/Nursing	184, 766 67, 887		184, 766			
10.00	Assi stants/Ai des	07,007		07,007	1, 396. 75	42.40	10.00
17.00	Total Nursing (sum of lines 14 through 16)	255, 418		255, 418	3, 462, 60	73.76	17.00
18.00	Physical Therapists	130, 398		130, 398			
	Physical Therapy Assistants	0		(00,0)		0.00	
	Physical Therapy Aides	0			0.00	0.00	
	Occupational Therapists	123, 983		123, 983			
22.00	Occupational Therapy Assistants	0		(0.00	
	Occupational Therapy Aides	0					
24.00	Speech Therapi sts	58, 251		58, 251			
25.00	Respiratory Therapists	0		(
	Other Medical Staff	0		(26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	CONTINUING CARE AT LANTERN HILL Provider No.: 31552		eu of Form CMS Worksheet S-	
		From 01/01/2021 To 12/31/2021		
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00		RVL		4.00
5.00		RHX		5.00
6.00 7.00		RHL RMX		6.00 7.00
8.00		RML		8.00
9.00		RLX		9.00
10.00		RUC		10.00
11.00		RUB		11.00
12.00 13.00		RUA RVC		12.00
14.00		RVB		14.00
15.00		RVA		15.00
16.00		RHC		16.00
17.00		RHB		17.00
18.00 19.00		RHA RMC		18.00
20.00		RMB		20.00
21.00		RMA		21.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00		ES3		24.00
25. 00 26. 00		ES2 ES1		25.00 26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30.00		HD1		30.00
31. 00 32. 00		HC2 HC1		31.00
33.00		HB2		33.00
34.00		HB1		34.00
35.00		LE2		35.00
36.00		LE1		36.00
37. 00 38. 00		LD2 LD1		37.00 38.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00 44.00		CE2 CE1		43.00
45.00		CD2		44.00
46.00		CD1		46.00
47.00		CC2		47.00
48.00		CC1		48.00
49.00 50.00		CB2 CB1		49.00 50.00
51.00		CA2		51.00
52.00		CA1		52.00
53.00		SE3		53.00
54.00		SE2		54.00 55.00
55. 00 56. 00		SE1 SSC		55.00
57.00		SSB		57.00
58.00		SSA		58.00
59.00		I B2		59.00
60.00		IB1		60.00
61. 00 62. 00		I A2 I A1		61.00 62.00
63.00		BB2		63.00
64. 00		BB1		64.00
65.00		BA2		65.00
66. 00 67. 00		BA1 PE2		66.00 67.00
68.00		PE2 PE1		67.00
69.00		PD2		69.00
70.00		PD1		70.00
71.00		PC2		71.00
72.00		PC1		72.00
73. 00 74. 00		PB2 PB1		73.00 74.00
74 (10)				1/1/1/1

Health Financial Systems CONTINUING CARE AT LA	NTERN HILI	-	In Lie	u of Form CMS-	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315523	Period:	Worksheet S-	7
			From 01/01/2021 To 12/31/2021		
			Group	Days	
			1.00	2.00	
76.00			PA1		76.00
99. 00			AAA		99.00
100. 00 TOTAL					100.00
		Expenses	Percentage	Y/N	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 A payments beginning 10/01/2003. Congress expected this increase expenses. For lines 101 through 106: Enter in column 1 the amou column 2 the percentage of total expenses for each category to line 1, column 3. Indicate in column 3 "Y" for yes or "N" for n with direct patient care and related expenses for each category (See instructions)	to be used nt of the total SNF o if the s	for direct expense for revenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

Cost Center Description Salaries Other Ital (col.) Reclass(Field) Reclass(Field) </th <th></th> <th>Financial Systems CC SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF</th> <th>NTINUING CARE AT</th> <th></th> <th></th> <th>Peri od:</th> <th>u of Form CMS-: Worksheet A</th> <th>2540-10</th>		Financial Systems CC SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	NTINUING CARE AT			Peri od:	u of Form CMS-: Worksheet A	2540-10
Cost Center Description Selarios Other Total (col.) Reclass fraut	RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provider	NO 313523			
Example Cost Center Description Salaries Other Prof all solaries (col. 2) Total (col. 2) (col. 3) Total (col. 3) (col. 3) Trial solaries (col. 3) Trial (col. 3) <thtrial (col. 3) <thtrial (col. 3) <tht< th=""><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></tht<></thtrial </thtrial 								
Increase/Board Increas		Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cati		
Image: (Fr: West) food 2.00 3.00 4.00 5.00 1 0.00 0.00200 (AP REL COSTS - BUXSA & FUTURES 2.00 20.863.073 20.863.073 20.863.073 0.2086.070 3.00 20.853.071 20.863.072 0.2086.070 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.529.167 3.50 6.00 0.00000 UIESAEPHAG 1.859.263 5.00 0.70 0.00000 0.1858.25PHAG 0.0000 1.859.263 5.00 0.00000 0.00000 1.859.263 5.00 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000000000000000000000000000000					+ col. 2)			
Loo 2.00 3.00 Å.6) 5.00 1.00 ÖCRÖQ (ÅP REL COST CENTERS 20,863,093 20,963,093 0 20,863,093 1.00 2.00 ÖCRÖQ (ÅP REL COST S - BIDS & FLXTURES 20,863,093 20,963,093 0 20,863,093 1.00 2.00 ÖCRÖQ (ÅP REL COST S - MOVALE COLI PMENT 361,162 51,162 51,172 631,182 50 1.00 ÖCRÖQ (ÅVIN ISTRATURE & GENERAL 1.333,700 1.345,955 -19,740 2.66,649 0 5.00 ÖCRÖQ (LAITO PERATURU, MAINT & REPAIRS 713,308 1.145,955 1.989,223 5.00 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 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
ENERGY COUNTRY 1.00 2.00 3.00 4.00 5.00 1.00 D0100 (CAP REL COSTS - BLDGS & FIXTURES 20, 863, 093 0, 20, 863, 093 0, 20, 863, 093 1, 00 3.00 D0200 EAP REL COSTS - BLDGS & FIXTURES 307, 664 33, 116, 1503 3, 227, 167 0 3, 227, 167 0 3, 227, 167 0 3, 227, 167 0 3, 227, 167 0 3, 227, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 3, 257, 167 0 0 0, 200, 200, 200, 200, 200, 200, 200, 2							COI. 4)	
DEMERAL SERVICE COST CENTERS 20, 663, 073 20, 20, 663, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 20, 863, 073 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 0 33, 122 100 33, 122 100 100			1 00	2 00	3.00		5.00	
1.00 00100 CAP REL COSTS - BLOS & FIXTURES 20.663,093 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.683,093 0 20.684,284 40.633,093 0 20.685,093 0 20.685,093 0 20.685,093 0 20.686,283 0 53.523 22.686,283 0 1.652,263 0 0 0 0 0 0 0 0 0 0 0 0 0		GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
3.00 00300 DMMLOVE BENEFITS 36.7, 664 3, 161, 503 35.29, 167 3, 25, 266, 348 -19, 740 3, 25, 266, 348 -19, 740 2, 666, 448 4.0 5.00 00500 PLANT OPERATLON, MAINT, & REPAIRS 713, 308 1, 145, 955 1, 859, 263 5.00 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 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	1.00			20, 863, 093	20, 863, 0	93 0	20, 863, 093	1.00
4.00 00400 AMMI MISTATIVE & GENERAL 1.333,700 1,352,688 2.666,638 -19,740 2.666,648 4.0 0.00 00500 LAINT OPERATION, MAIT & REPAIRS 713,308 1,145,952,268 2.666,648 4.0 0.00 00000 DETARY 191,601 5.5,521 248,122 0 2.48,122 0 9.0 9.0 9.0 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 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 0.0 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	2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		831, 182	831, 1	32 0	831, 182	2.00
5.00 00500 PLANT OPERATION, MAINT, & REPARS 713, 308 1, 145, 955 1, 859, 263 0 1, 659, 263 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00		367, 664	3, 161, 503			3, 529, 167	3.00
6.00 00600 LAUNDRY & LINEN SERVICE 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <								
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8.00 00800 DIETARY 191.601 56.521 248.122 0 248.122 0 248.122 0 248.122 0 248.122 0 248.122 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 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 0 0 0 0 0 0 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			0	0		0 0	-	
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10. 00 01000 CENTRAL SERVICES & SUPPLY 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <			191,601	56, 521	248, 1.			
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94. 00 09400 PATI ENTS LAUNDRY 0 0 0 94. 00 95. 00 09500 OTHER NON REI MBURSABLE COST 5, 425, 171 12, 375, 789 17, 800, 960 0 17, 800, 960 94. 00				0			-	
95. 00 09500 OTHER NON REI MBURSABLE COST 5, 425, 171 12, 375, 789 17, 800, 960 0 17, 800, 960 95. 00				0				
			5 425 171	12 375 789	17 800 9	50 0	-	
	100.00		11, 458, 865	41, 833, 964				

ECLAS	Financial Systems C SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES	Provi der	No.: 315523		Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 9/7/2022 1:57	epared: 7 pm
	Cost Center Description	Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		- I	77772022 1.07	
		6.00	7.00	1			
	GENERAL SERVICE COST CENTERS	0.00	7100	1			
00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	20, 863, 093				1.00
00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	831, 182				2.0
00	00300 EMPLOYEE BENEFITS	-178, 626	3, 350, 541	1			3.0
00	00400 ADMINISTRATIVE & GENERAL	-1,061,445	1,605,203	1			4.0
00	00500 PLANT OPERATION, MAINT. & REPAIRS	-57, 511	1, 801, 752	1			5.0
00	00600 LAUNDRY & LINEN SERVICE	0	C	1			6.0
00	00700 HOUSEKEEPI NG	0	C				7.0
00	00800 DI ETARY	-49, 273	198, 849				8.0
00	00900 NURSING ADMINISTRATION	0	C				9.0
D. 00	01000 CENTRAL SERVICES & SUPPLY	0	C				10.0
1.00	01100 PHARMACY	0	C				11.0
2.00	01200 MEDICAL RECORDS & LIBRARY	0	C				12.0
3.00	01300 SOCIAL SERVICE	0	C				13.0
4.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C				14.0
5.00	01500 OTHER GENERAL SERVICE COST	-12, 456	535, 525				15.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00	03000 SKILLED NURSING FACILITY	-202, 999	4, 257, 897	7			30.0
1.00	03100 NURSING FACILITY	0	C				31.0
3.00	03300 OTHER LONG TERM CARE	0	C				33.0
	ANCILLARY SERVICE COST CENTERS						
0. 00	04000 RADI OLOGY	0	22, 409	1			40.0
1.00	04100 LABORATORY	0	29, 942	1			41. C
2.00	04200 I NTRAVENOUS THERAPY	0	14, 145				42.0
3.00	04300 OXYGEN (INHALATION) THERAPY	0	C				43.0
4.00	04400 PHYSI CAL THERAPY	0	129, 567	1			44. C
	04500 OCCUPATI ONAL THERAPY	0	123, 983				45. C
5.00	04600 SPEECH PATHOLOGY	0	58, 251				46.0
7.00	04700 ELECTROCARDI OLOGY	0	0				47.0
3.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22, 235	1			48.0
9.00	04900 DRUGS CHARGED TO PATIENTS	0	84, 985	1			49.0
D. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1			50.0
1.00 2.00	05100 SUPPORT SURFACES	0		1			51.0
2.00	05200 OTHER ANCI LLARY SERVICE COST CENTER OUTPATI ENT SERVICE COST CENTERS	0	L C	/			52.0
D. 00	06000 CLINIC	0	C				60.0
	06300 OTHER OUTPATIENT SERVICE COST	0	0	1			63.0
5. 00	OTHER REIMBURSABLE COST CENTERS			1			- 00.0
0. 00	07000 HOME HEALTH AGENCY COST	0	C				70.0
1.00	07100 AMBULANCE	0	C				71.0
4.00	07400 OTHER REIMBURSABLE COST	0	C	1			74.0
	SPECIAL PURPOSE COST CENTERS			1			
D. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	C)			80. 0
1.00	08100 INTEREST EXPENSE	0	C				81.0
2.00	08200 UTI LI ZATI ON REVI EW	0	C				82.0
4.00	08400 OTHER SPECIAL PURPOSE COST	0	C				84.0
9.00	SUBTOTALS (sum of lines 1-84)	-1, 562, 310	33, 929, 559				89.0
	NONREI MBURSABLE COST CENTERS						
D. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C)			90.0
. 00	09100 BARBER AND BEAUTY SHOP	0	C				91.0
2.00	09200 PHYSICIANS PRIVATE OFFICES	0	C				92.0
3.00	09300 NONPAI D WORKERS	0	C				93.0
1.00	09400 PATIENTS LAUNDRY	0	C				94.0
5.00	09500 OTHER NON REIMBURSABLE COST	350, 859	18, 151, 819				95.0
). 00)0. 00		-1, 211, 451					100.0

Health Financial Systems	CONTINUING CARE AT LANTERN HIL	TINUING CARE AT LANTERN HILL In Lieu of			
RECLASSI FI CATI ONS	Provi der		Period: From 01/01/2021	Worksheet A-6	
			To 12/31/2021	Date/Time Pre 9/7/2022 1:57	pared: pm
	Cost Center	Line #	Sal ary	Non Salary	
	2.00	3.00	4.00	5.00	
(1) A - MEDICAL DIRECTOR					
1.00	SKILLED NURSING FACILITY	30.00	0 0	19, 740	1.00
(1) B - RECLASS THERAPY EXPENSE					
2.00	OCCUPATI ONAL THERAPY	45.00	0 0	123, 983	2.00
(1) C - RECLASS THERAPY EXPENSE					
3.00	SPEECH PATHOLOGY	46.00	0 0	58, 251	3.00
TOTALS					
100.00	Total Reclassifications (Sum	1	0	201, 974	100.00
	of columns 4 and 5 must				
	equal sum of columns 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	CONTINUING CARE AT LANTERN HI	L	In Lieu of Form CMS-2		
RECLASSI FI CATI ONS	Provi der		Period: Worksheet A-6 From 01/01/2021		
			To 12/31/2021	Date/Time Pre 9/7/2022 1:57	pared:
	Cost Center	Line #	Sal ary	Non Salary	
	6.00	7.00	8.00	9.00	
(1) A - MEDICAL DIRECTOR					
1.00	ADMINISTRATIVE & GENERAL	4.0	0 0	19, 740	1.00
(1) B - RECLASS THERAPY EXPENSE					
2.00	PHYSI CAL THERAPY	44.0	0 0	123, 983	2.00
(1) C - RECLASS THERAPY EXPENSE					
3.00	PHYSI CAL THERAPY	44.0	0 0	58, 251	3.00
TOTALS					
100.00			0	201, 974	100. 00

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

Heal th	Financial Systems CO	NTINUING CARE A	AT LANTERN HILL			In Lie	u of Form CMS-2	2540-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315523	Peri		Worksheet A-7	
					Fron To	n 01/01/2021 12/31/2021	Date/Time Prep 9/7/2022 1:57	pared: pm
				Acqui si ti on	IS			
	Description	Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5						
1.00	Land	0	0		0	0	0	1.00
2.00	Land Improvements	26, 685	9, 510		0	9, 510	0	2.00
3.00	Buildings and Fixtures	214, 616, 368	17, 907, 579		0	17, 907, 579	0	3.00
4.00	Building Improvements	997, 123	111, 782		0	111, 782	0	4.00
5.00	Fixed Equipment	2, 213, 589	397, 148		0	397, 148	0	5.00
6.00	Movable Equipment	4, 196, 566	203, 095		0	203, 095	0	6.00
7.00	Subtotal (sum of lines 1-6)	222, 050, 331	18, 629, 114		0	18, 629, 114	0	7.00
8.00	Reconciling Items	0	0		0	0	0	8.00
9.00	Total (line 7 minus line 8)	222, 050, 331	18, 629, 114		0	18, 629, 114	0	9.00
	Description	Endi ng Bal ance	Fully					
			Depreciated					
			Assets					
		6.00	7.00					
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0					1.00
2.00	Land Improvements	36, 195	0					2.00
3.00	Buildings and Fixtures	232, 523, 947	0					3.00
4.00	Building Improvements	1, 108, 905	0					4.00
5.00	Fixed Equipment	2, 610, 737	0					5.00
6.00	Movable Equipment	4, 399, 661	0					6.00
7.00	Subtotal (sum of lines 1–6)	240, 679, 445	0					7.00
8.00	Reconciling Items	0	0					8.00
9.00	Total (line 7 minus line 8)	240, 679, 445	0					9.00

JUST	MENTS TO EXPENSES		Provi der	No.: 315523	Period: From 01/01/2021	Worksheet A-8	
					To 12/31/2021	Date/Time Pre 9/7/2022 1:57	
					Classification on ch the Amount is		
					ch the Anount 13	to be Aujusted	
	Description (1)	(2) Basis For	Amount		t Center	Line No.	
	bescription (1)	Adjustment	Amount	CUS	t center	LITTE NO.	
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds (chapter 2)		C			0.00	1.0
00	Trade, quantity, and time discounts (chapter		C	6		0.00	2.0
~~	8)						
00 00	Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers		0			0.00 0.00	3.0
00	(chapter 8)		0			0.00	4.0
00	Telephone services (pay stations excluded)		C			0.00	5.0
00	(chapter 21) Television and radio service (chapter 21)		0			0.00	6.0
00	Parking lot (chapter 21)		0			0.00	
00	Remuneration applicable to provider-based	A-8-2	C)			8.
	physician adjustment						
00	Home office cost (chapter 21) Sale of scrap, waste, etc. (chapter 23)		0			0.00 0.00	
. 00	Nonallowable costs related to certain		0			0.00	
	Capital expenditures (chapter 24)						
2.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-1, 085, 160				12.
. 00	Laundry and Linen service		C			0.00	13.
. 00	Revenue - Employee meals		C)		0.00	
. 00	Cost of meals - Guests		C			0.00	
. 00	Sale of medical supplies to other than patients		C			0.00	16.
. 00	Sale of drugs to other than patients		C			0.00	17.
. 00	Sale of medical records and abstracts		C)		0.00	18.
. 00	Vending machines		0			0.00	
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		C			0.00	20.
. 00	Interest expense on Medicare overpayments		C			0.00	21.
	and borrowings to repay Medicare						
00	overpayments		0			82.00	22
. 00	Utilization reviewphysicians' compensation (chapter 21)		U	UTI LI ZATI ON	REVIEW	82.00	22.
. 00	Depreciationbuildings and fixtures		0	CAP REL COST	rs – BLDGS &	1.00	23.
. 00	Depressi ati op moveble equi prest		0	FIXTURES		2.00	24
. 00	Depreciationmovable equipment		U	EQUI PMENT	S - MUVABLE	2.00	24.
. 00	INCOME OFFSETS	В	-531	1	AL SERVICE COST	15.00	25.
. 00	INCOME OFFSETS	В		EMPLOYEE BEN		3.00	
. 00	INCOME OFFSETS	В			SING FACILITY	30.00	
. 00 . 00	I NCOME OFFSETS I NCOME OFFSETS	BB			VE & GENERAL FLON, MAINT. &	4.00 5.00	
			57, 511	REPAI RS	non, wann d	5.00	27.
. 00	INCOME OFFSETS	В		DI ETARY		8.00	
. 00	BAD DEBT EXPENSE	A			VE & GENERAL	4.00	
		A			SING FACILITY	30.00	
u. UU	Total (sum of lines 1 through 99) (Transfer		-1, 211, 451				100.

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315523 Period: From 01/01/2021 To 12/31/2021 Worksheet A-8-1 Parts I-II Date/Time Prepared: 9/7/2022 1:57 pm Image: Cost Center in the image: Cost Center in the prepared in th
To 12/31/2021 Date/Time Prepared: 9/7/2022 1:57 pm Description Date/Time Prepared: 9/7/2022 1:57 pm Description Expense I tems 1.00 2.00 3.00 PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: DI ETARY DI ETARY 1.00 1.00 3.00 15.000THER GENERAL SERVICE COST 01 ETARY 1.00 2.00 3.00 15.000THER GENERAL SERVICE COST 01 ETARY 1.00 2.00 3.00 3.00 OSKILLED NURSING FACILITY SKILLED NURSING FACILITY 3.00 4.00 3.00 EMPLOYEE BENEFITS 4.00 5.00 4.00 ADMINI STRATI VE & GENERAL EMPLOYEE BENEFITS 6.00 0.00 0.00 0.00 0.00 9.00 10.00 0.00 0.00 0.00 0.00 10.00 12. 10 to Worksheet A-8, column 3, line 0.00 10.00
Line No. Cost Center Expense I tems 1.00 2.00 3.00 PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 8.00 DI ETARY 0 1.00 15.00 OTHER GENERAL SERVICE COST 01 ETARY 01 ETARY 1.00 2.00 30.00 OTHER GENERAL SERVICE COST 01 ETARY 1.00 3.00 95.00 OTHER NON REIMBURSABLE COST 01 ETARY 1.00 4.00 95.00 OTHER NON REIMBURSABLE COST 01 ETARY 3.00 5.00 3.00 EMPLOYEE BENEFITS EMPLOYEE BENEFITS 5.00 6.00 0.00 0.00 0.00 7.00 8.00 0.00 0.00 0.00 0.00 0.00 9.00 10.00 10.00 10.00 10.00
I. 002.003.00PART 1. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:I. 001. 008. 00 DI ETARY 15. 00 OTHER GENERAL SERVICE COST 30. 00 SKI LLED NURSING FACILITY 95. 00 OTHER NON REI MBURSABLE COST 3. 00 EMPLOYEE BENEFITS 4. 00DI ETARY OTHER GENERAL SERVICE COST SKI LLED NURSING FACILITY SKI LLED NURSING FACILITY
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR 1.00 CLAIMED HOME OFFICE COSTS: 8.00 DI ETARY DI ETARY 1.00 15.00 OTHER GENERAL SERVICE COST 01 ETARY 1.00 3.00 15.00 OTHER GENERAL SERVICE COST SKILLED NURSING FACILITY 3.00 4.00 00 15.00 OTHER NON REIMBURSABLE COST SKILLED NURSING FACILITY 3.00 5.00 3.00 EMPLOYEE BENEFITS SHILED NURSING FACILITY 3.00 6.00 7.00 3.00 EMPLOYEE BENEFITS EMPLOYEE BENEFITS 5.00 7.00 0.00 0.00 0.00 0.00 7.00 8.00 0.00 0.00 0.00 0.00 7.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12. 0.00 0.00 0.00
CLAI MED HOME OFFICE COSTS: 8.00 DI ETARY DI ETARY 1.00 2.00 15.00 OTHER GENERAL SERVICE COST 0.1ETARY 0.00 THER GENERAL SERVICE COST 0.1ETARY 2.00 3.00 15.00 OTHER GENERAL SERVICE COST 0.00 SKI LLED NURSING FACILITY 0.00 SKI LLED NURSING FACILITY 3.00 4.00 0.00 OTHER NON REI MBURSABLE 0.00 0.00 0.00 0.00 5.00 3.00 EMPLOYEE BENEFITS 3.00 6.00 7.00 3.00 6.00 4.00 ADMI NI STRATI VE & GENERAL 6.00 7.00 8.00 0.00 7.00 0.00 0.00 0.00 0.00 0.00 7.00 8.00 0.00 0.00 0.00 0.00 7.00 8.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00
1.00 8.00 DI ETARY DI ETARY 1.00 2.00 15.00 OTHER GENERAL SERVI CE COST OTHER GENERAL SERVI CE COST 2.00 3.00 30.00 SKI LLED NURSI NG FACI LI TY SKI LLED NURSI NG FACI LI TY 3.00 4.00 95.00 OTHER NON REI MBURSABLE COST SKI LLED NURSI NG FACI LI TY 3.00 5.00 3.00 EMPLOYEE BENEFI TS EMPLOYEE BENEFI TS 4.00 6.00 4.00 ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL 6.00 7.00 0.00 0.00 0.00 0.00 7.00 8.00 0.00 0.00 0.00 0.00 10.00 10.00 TOTALS (sum of lines 1-9). Transfer col umn 0.00 0.00 10.00 10.00 10.00 12. 100 to Worksheet A-8, col umn 3, line 10.00 10.00 10.00
3.0030.00SKILLED NURSING FACILITY 95.00SKILLED NURSING FACILITY OTHER NON REIMBURSABLE EMPLOYEE BENEFITS ADMINISTRATIVE & GENERALSKILLED NURSING FACILITY OTHER NON REIMBURSABLE EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL3.006.00.000.000.00.007.000.000.000.008.009.0010.00TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line10.00
4.0095.00OTHER NON REIMBURSABLE COST 3.00 EMPLOYEE BENEFITSOTHER NON REIMBURSABLE EMPLOYEE BENEFITS4.006.003.00 EMPLOYEE BENEFITS 4.00 ADMINISTRATIVE & GENERAL 0.005.00ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL6.007.000.000.000.007.008.000.000.000.008.009.0010.00TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line10.00
5.00 3.00 EMPLOYEE BENEFITS EMPLOYEE BENEFITS 5.00 6.00 4.00 ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL 6.00 7.00 0.00 0.00 0.00 7.00 8.00 0.00 0.00 0.00 7.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12. 10.00 10.00
6.00 4.00 ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL 6.00 7.00 0.00 0.00 0.00 7.00 8.00 0.00 0.00 0.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12. 10.00 10.00
7.00 0.00 0.00 7.00 8.00 0.00 0.00 0.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 0.00 10.00 6, line 100 to Worksheet A-8, column 3, line 10.00 10.00
8.00 0.00 0.00 8.00 9.00 9.00 TOTALS (sum of lines 1-9). Transfer column 0.00 0.00 10.00 10.00 TOTALS (sum of lines 1-9). Transfer column 3, line 10.00 10.00 10.00
9.00 0.00 0.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12. 0.00 10.00
10.00 TOTALS (sum of lines 1-9). Transfer column 10.00 6, line 100 to Worksheet A-8, column 3, line 10.00 12.
6, line 100 to Worksheet A-8, column 3, line 12.
12.
Amount Amount Adjustments
Allowable In Included in (col. 4 minus
Cost Wkst. A, col. col. 5)
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:
1.00 0 45,864 -45,864 1.00
2.00 0 11,925 -11,925 2.00
3. 00 307, 420 460, 631 -153, 211 3. 00
4.00 2,341,447 1,990,588 350,859 4.00
5.00 0 178,525 -178,525 5.00
6.00 0 1,046,494 -1,046,494 6.00
7.00 0 0 7.00
8.00 0 0 8.00
10. 00 TOTALS (sum of lines 1-9). Transfer column 2,648,867 3,734,027 -1,085,160 10.00
6, line 100 to Worksheet A-8, column 3, line 12.

Health Financial Systems C	CONTINUING CARE AT LANTERN HILL			In Lieu of Form CMS-2540		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANI OFFICE COSTS	ZATIONS AND HOME	E	Provider No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8- Parts I-II Date/Time Prep 9/7/2022 1:57	bared:
	Symbol (1)		Name	Percentage of		
				Ownership		
	1.00		2.00	3.00		
	ZATION(C) AND (O					

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

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

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

1.00 B	0.00	1.00
2.00	0.00	2.00
3.00	0.00	3.00
4.00	0.00	4.00
5.00	0.00	5.00
6.00	0.00	6.00
7.00	0.00	7.00
8.00	0.00	8.00
9.00	0.00	9.00
10.00	0.00	10.00
100.00 G. Other (financial or non-financial)	0.00	100.00
speci fy:		

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

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

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

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

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

related organization.

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

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

	Rel ated Organi	zation(s) and/	or Home Office						
	Name	Percentage of	Type of Business						
		Ownershi p							
	4.00	5.00	6.00						
PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. 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.

for purposed of or arming for mour comone			
1.00	ERICKSON LIVING	100.00 HOME OFFICE	1.00
2.00		0.00	2.00
3.00		0.00	3.00
4.00		0.00	4.00
5.00		0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financ	cial)	0.00	100.00
speci fy:			

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

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

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

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

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

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

	Financial Systems Co LLOCATION - GENERAL SERVICE COSTS	ONTI NUI NG CARE AT	Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021	u of Form CMS-: Worksheet B Part I Date/Time Pre 9/7/2022 1:57	epared:
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
	r	0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	20, 863, 093	20, 863, 093	001 1	0.0		1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	831, 182 3, 350, 541	0	831, 1	0 3, 350, 541		2.00
1.00	00400 ADMI NI STRATI VE & GENERAL	1, 605, 203	0		0 3, 350, 541	2, 008, 100	
F. 00 5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 801, 752	0		0 215, 483	2,008,100	
5.00	00600 LAUNDRY & LINEN SERVICE	0	0		0 213, 403	2,017,233	
7.00	00700 HOUSEKEEPI NG	0	0		0 0	0	
3.00	00800 DI ETARY	198, 849	o		0 57, 881	256, 730	
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
0.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
1.00	01100 PHARMACY	0	О		0 0	0	11.00
2.00	01200 MEDI CAL RECORDS & LI BRARY	0	О		0 0	0	12.0
	01300 SOCIAL SERVICE	0	0		0 0	0	13.0
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
5.00	01500 OTHER GENERAL SERVICE COST	535, 525	0		0 120, 158	655, 683	15.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	4, 257, 897	1, 681, 788	67, 0		6, 921, 918	
	03100 NURSING FACILITY	0	0		0 0	0	
33.00	O3300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
10.00	ANCI LLARY SERVI CE COST CENTERS	22, 409	0		0 0	22, 409	40.00
11.00	04100 LABORATORY	22, 409	0		0 0	22, 409	
12.00	04200 INTRAVENOUS THERAPY	14, 145	0			14, 145	
13.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
4.00	04400 PHYSI CAL THERAPY	129, 567	0		0 0	129, 567	
15.00	04500 OCCUPATI ONAL THERAPY	123, 983	0		0 0	123, 983	
16.00	04600 SPEECH PATHOLOGY	58, 251	0		0 0	58, 251	46.00
17.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.0
18.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 235	0		0 0	22, 235	48.0
19.00	04900 DRUGS CHARGED TO PATIENTS	84, 985	0		0 0	84, 985	49.0
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTER	0	0		0 0	0	52.0
	OUTPATIENT SERVICE COST CENTERS						
		0	0		0 0	0	
53.00	06300 OTHER OUTPATIENT SERVICE COST OTHER REIMBURSABLE COST CENTERS	0	U		0 0	0	63.00
0 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0		0 0	0	
	07400 OTHER REIMBURSABLE COST	0	0		0 0	0	
	SPECIAL PURPOSE COST CENTERS		-1			-	1
30.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
	08100 INTEREST EXPENSE						81.00
32.00	08200 UTI LI ZATI ON REVI EW						82.00
	08400 OTHER SPECIAL PURPOSE COST	0	0		0 0	0	
39.00	SUBTOTALS (sum of lines 1-84)	33, 929, 559	1, 681, 788	67, 0	02 1, 711, 650	12, 345, 183	89.00
	NONREI MBURSABLE COST CENTERS	1			-		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		U 0	0	
93.00	09300 NONPALD WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY	10 151 010	10 101 205	7/ 4 4		0 20 724 105	
95.00	09500 OTHER NON REIMBURSABLE COST	18, 151, 819	19, 181, 305	764, 1	80 1, 638, 891	39, 736, 195 0	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	0			0	

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2021	Worksheet B Part I	
					To 12/31/2021	Date/Time Pre 9/7/2022 1:57	epared: pm
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION, MAINT. &	LINEN SERVICE	-		
			REPAI RS				
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	1					1
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	2,008,100					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	80, 897	2, 098, 132				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	0		0		6.00
7.00	00700 HOUSEKEEPI NG	0	0		0 0		7.00
8.00	00800 DI ETARY	10, 296	0		0 0	267, 026	
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
10.00 11.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0			0	
	01200 MEDICAL RECORDS & LIBRARY	0	0			0	
	01300 SOCI AL SERVI CE	0	0		0 0	0	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
	01500 OTHER GENERAL SERVICE COST	26, 295	0		0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
	03000 SKILLED NURSING FACILITY	277, 590	169, 132		0 0	40, 822	
	03100 NURSING FACILITY	0	0		0 0	0	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	33.00
40.00	04000 RADI OLOGY	899	0		0 0	0	40.00
	04100 LABORATORY	1, 201	0		0 0	0	
	04200 I NTRAVENOUS THERAPY	567	0		0 0	0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
	04400 PHYSI CAL THERAPY	5, 196	0		0 0	0	
45.00	04500 OCCUPATI ONAL THERAPY	4,972	0		0 0	0	
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	2, 336	0		0 0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	892	0			0	
	04900 DRUGS CHARGED TO PATIENTS	3, 408	0		0 0	0	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	
	05100 SUPPORT SURFACES	0	0		o o	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTER	0	0		0 0	0	52.00
	OUTPATIENT SERVICE COST CENTERS	1		1	a a		1 / 2 . 2 .
60.00 63.00	06000 CLINIC 06300 OTHER OUTPATIENT SERVICE COST	0	0 0		0 0 0 0	0	
03.00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0		0 0	0	
74.00	07400 OTHER REIMBURSABLE COST	0	0		0 0	0	74.00
	SPECIAL PURPOSE COST CENTERS	1		1			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW						81.00 82.00
	08400 OTHER SPECIAL PURPOSE COST	0	0		o o	0	1
89.00	SUBTOTALS (sum of lines 1-84)	414, 549	169, 132		0 0	40, 822	1
	NONREI MBURSABLE COST CENTERS			1	-		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
92.00		0	0		0 0	0	
92. 00 93. 00	09300 NONPALD WORKERS		~			^	
92.00 93.00 94.00	09400 PATIENTS LAUNDRY	1 502 551	1 020 000		0 0	0	
92.00 93.00 94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NON REIMBURSABLE COST	0 1, 593, 551 0	0 1, 929, 000 0			226, 204	95.00
92.00 93.00 94.00	09400 PATIENTS LAUNDRY	0 1, 593, 551 0 0	0 1, 929, 000 0 0		0 0 0 0 0 0 0 0		95.00 98.00

		ONTINUING CARE A				u of Form CMS-	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021		pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00 4.00 5.00 6.00 7.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFI TS 00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS 00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8.00 9.00 10.00 11.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	0 0	C		0		8.00 9.00 10.00 11.00
12.00	01200 MEDICAL RECORDS & LI BRARY	0	C		0 0		12.00
13.00	01300 SOCIAL SERVICE	0	C		0 0	0	
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 OTHER GENERAL SERVICE COST INPATIENT ROUTINE SERVICE COST CENTERS	000	(0 0 0 0	0	
30.00	03000 SKI LLED NURSI NG FACI LI TY	0	((0 0		
31.00 33.00	03100 NURSING FACILITY 03300 OTHER LONG TERM CARE	0	0		0 0 0 0	0	
	ANCILLARY SERVICE COST CENTERS			1			
40.00	04000 RADI OLOGY	0	((0 0	0	
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	(0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C		0 0	0	
44.00	04400 PHYSI CAL THERAPY	0	C		0 0	0	
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	(0 0	0	45.00 46.00
48.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	48.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	þ	0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	(0 0	0	
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTER	0	0		0 0	-	
	OUTPATIENT SERVICE COST CENTERS	· · ·		1			
60.00 63.00	06000 CLINIC 06300 OTHER OUTPATIENT SERVICE COST	0	((0 0 0 0		
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		И	0 0	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	C		0 0	0	
71.00 74.00	07100 AMBULANCE 07400 OTHER REIMBURSABLE COST	0	C		0 0		
	SPECIAL PURPOSE COST CENTERS	<u> </u>		4	0	0	74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00 84.00	08200 UTI LI ZATI ON REVI EW 08400 OTHER SPECIAL PURPOSE COST	0	C		0 0	0	82.00 84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	C		0 0		
	NONREI MBURSABLE COST CENTERS	-1		-1		-	
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	((0 0	-	
92.00	09200 PHYSI CLANS PRI VATE OFFICES	0	(0 0	0	
93.00	09300 NONPAI D WORKERS	0	C		0 0	0	•
94.00	09400 PATIENTS LAUNDRY	0	0	2	0 0	0	
95.00 98.00	09500 OTHER NON REIMBURSABLE COST Cross Foot Adjustments	0	ſ		0	0	95.00 98.00
90.00 99.00	Negative Cost Centers	0	0	Ď	0 0	0	99.00
100.00	TOTAL	0	C)	0 0	0	100.00

Heal th	Financial Systems CC	ONTINUING CARE	AT LAM	NTERN HILL		In Li	eu of Form CMS-	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS			Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021		epared: 7 pm
				R GENERAL				
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON		ERVI CE COST	Subtotal	Post Stepdown Adjustments	Total	
		14.00	-	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	1	1				1	
1.00 2.00 3.00 4.00 5.00 6.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE							1.00 2.00 3.00 4.00 5.00 6.00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY							7.00
11.00	00900 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY							8.00 9.00 10.00 11.00 12.00
	01300 SOCIAL SERVICE							13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	C		(01 070				14.00
15.00	01500 OTHER GENERAL SERVICE COST	C)	681, 978				15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	C		45, 082	7, 454, 5	44 (7, 454, 544	30.00
31.00	03100 NURSING FACILITY	C	D	0		0 0		
33.00	O3300 OTHER LONG TERM CARE	C		0		0 (0 0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS	C	1	0	23, 3	08 (23, 308	40.00
	04000 RADI OLOGY 04100 LABORATORY			0	23, 3			
	04200 I NTRAVENOUS THERAPY	C	Ď	0	14, 7			
43.00	04300 OXYGEN (INHALATION) THERAPY	C	D	0		0 0	o o	43.00
	04400 PHYSI CAL THERAPY	C	D	0	134, 7			
	04500 OCCUPATIONAL THERAPY		0	0	128, 9			
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY			0	60, 5	87 (0 (
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			0	23, 1	з ,	23, 127	
	04900 DRUGS CHARGED TO PATIENTS	C		0	88, 3			
	05000 DENTAL CARE - TITLE XIX ONLY	C	D	0		0 (o 0	50.00
	05100 SUPPORT SURFACES	C		0		0 0		
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTER	C	<u>ן</u>	0		0 (0 0	52.00
60.00	OUTPATI ENT SERVI CE COST CENTERS 06000 CLI NI C	C		0		0 (60.00
	06300 OTHER OUTPATIENT SERVICE COST			0				
	OTHER REIMBURSABLE COST CENTERS							
	07000 HOME HEALTH AGENCY COST	C		0		0 0		
	07100 AMBULANCE	C	2	0				
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS		<u>и</u>	0		0 (74.00
80, 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		1					80.00
	08100 INTEREST EXPENSE							81.00
	08200 UTILIZATION REVIEW							82.00
	08400 OTHER SPECIAL PURPOSE COST	C	D	0			0 0	
89.00	SUBTOTALS (sum of lines 1-84)	C)	45, 082	7, 959, 5	32 (7, 959, 532	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN			0		0		90.00
	09100 BARBER AND BEAUTY SHOP			0		0		
	09200 PHYSI CI ANS PRI VATE OFFI CES		þ	0		0 0		
	09300 NONPAI D WORKERS	C	D	0		0 0	o o	
	09400 PATIENTS LAUNDRY	C	2	0		0 (
95.00 98.00	09500 OTHER NON REIMBURSABLE COST		1	636, 896	44, 121, 8	46 (0 44, 121, 846 0 0	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers			0		0 0		
100.00	5	0	þ	681, 978	52, 081, 3	78 (52, 081, 378	
		,					•	•

ALLOCA	Financial Systems CC TION OF CAPITAL RELATED COSTS		Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021		
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RE BLDGS & FI XTURES	LATED COSTS MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
			1.00	2.00	2A	3.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS	0	C		0 0	-	
4.00	00400 ADMI NI STRATI VE & GENERAL	0	0		0 0	0	
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0		0 0	0	
6.00	00600 LAUNDRY & LINEN SERVICE	0	0			0	
7.00	00700 HOUSEKEEPING	0	U			0	
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	0	0			0	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0			0	
11.00	01100 PHARMACY	0	0			0	
12.00	01200 MEDICAL RECORDS & LI BRARY	0	0		0 0	0	
	01300 SOCIAL SERVICE	0	0		0 0	0 0	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C)	0 0	0	
15.00	01500 OTHER GENERAL SERVICE COST	0	C)	0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	1, 681, 788	67, 0	02 1, 748, 790	0	30.00
	03100 NURSING FACILITY	0	0		0 0		
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0 0	33.00
	ANCI LLARY SERVICE COST CENTERS			1			
40.00	04000 RADI OLOGY	0	0		0 0	-	
41.00	04100 LABORATORY	0	0			u u	
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0			0	
44.00	04400 PHYSI CAL THERAPY	0	0			0	
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0 0	
46.00	04600 SPEECH PATHOLOGY	0	0)	0 0	0	
47.00	04700 ELECTROCARDI OLOGY	0	C)	0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C		0 0	0 0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0 0	
51.00	05100 SUPPORT SURFACES	0	C		0 0	-	
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTER	0	0		0 0	0	52.00
	OUTPATIENT SERVICE COST CENTERS				0		
60.00 63.00	06000 CLINIC	0	0				
03.00	O6300 OTHER OUTPATIENT SERVICE COST OTHER REIMBURSABLE COST CENTERS	U U	0			<u>1</u>	03.00
70 00	07000 HOME HEALTH AGENCY COST	0	C		0 0	0	70.00
	07100 AMBULANCE	0	Ő		0 0		
	07400 OTHER REIMBURSABLE COST	0	C)	0 0	0	
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW						82.00
	08400 OTHER SPECIAL PURPOSE COST	0	0			0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	1, 681, 788	67,0	02 1, 748, 790	0 0	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	1
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
	09300 NONPAI D WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY	0	0		0 0	0	
95.00	09500 OTHER NON REIMBURSABLE COST	0	19, 181, 305	764, 1	80 19, 945, 485	0	
98.00	Cross Foot Adjustments				C		98.00
99.00	Negative Cost Centers		0		0 0	0	99.00
100.00	TOTAL	0	20, 863, 093	831, 1	82 21, 694, 275		100.00

LOCATI	ON OF CAPITAL RELATED COSTS		Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 9/7/2022 1:57	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	ENERAL SERVICE COST CENTERS	1 1		1			
	0100 CAP REL COSTS - BLDGS & FIXTURES						1.0
	0200 CAP REL COSTS - MOVABLE EQUIPMENT						2.0
	0300 EMPLOYEE BENEFITS						3.0
	0400 ADMINISTRATIVE & GENERAL	0					4. C
	0500 PLANT OPERATION, MAINT. & REPAIRS	0	C	D			5. C
00 00	0600 LAUNDRY & LINEN SERVICE	0	C		0		6.0
00 00	0700 HOUSEKEEPI NG	0	C		0 0		7.0
00 00	0800 DI ETARY	0	C		0 0	0	8.0
00 00	0900 NURSI NG ADMI NI STRATI ON	0	C		0 0	0	9.0
. 00 0	1000 CENTRAL SERVICES & SUPPLY	0	C		0 0	0	10.0
. 00 0	1100 PHARMACY	0	C		0 0	0	11.0
. 00 0	1200 MEDICAL RECORDS & LIBRARY	0	C		0 0	0	12.0
. 00 0	1300 SOCIAL SERVICE	0	C		0 0	0	13.0
. 00 0	1400 NURSING AND ALLIED HEALTH EDUCATION	0	C		0 0	0	14.0
. 00 0	1500 OTHER GENERAL SERVICE COST	0	C		0 0	0	15.0
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 SKILLED NURSING FACILITY	0	0)	0 0	0	1 30. 0
	3100 NURSING FACILITY	0	C		0 0	0	31.0
	3300 OTHER LONG TERM CARE	0	C		0 0		
	NCILLARY SERVICE COST CENTERS	-					
	4000 RADI OLOGY	0	(0 0	0	40.0
	4100 LABORATORY	0	(0 0		
	4200 I NTRAVENOUS THERAPY	0	(0 0	0	
	4300 OXYGEN (INHALATION) THERAPY	0	(0	
	4400 PHYSI CAL THERAPY	0				0	
	4500 OCCUPATI ONAL THERAPY	0				0	
	4600 SPEECH PATHOLOGY	0			0 0	0	
	4700 ELECTROCARDI OLOGY	0				0	
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	
	4900 DRUGS CHARGED TO PATIENTS	0			0 0	0	
	5000 DENTAL CARE - TITLE XIX ONLY	0			0 0	0	
	5100 SUPPORT SURFACES	0			0 0	0	
	5200 OTHER ANCILLARY SERVICE COST CENTER	0			0 0	0	
	UTPATIENT SERVICE COST CENTERS	0	(<u>и</u>	0 0	0	J 52. C
	6000 CLINIC	0	0	1	0 0	0	60.0
	6300 OTHER OUTPATIENT SERVICE COST	0	(0 0		
	THER REIMBURSABLE COST CENTERS	0	(<u>/</u>	0 0	0	1 03.0
	7000 HOME HEALTH AGENCY COST	0	(0 0	0	70.0
	7100 AMBULANCE	0			0 0		
	7400 OTHER REIMBURSABLE COST	0					1
		0	L. L	<u>и</u>	0 0	0	1 /4.0
	PECIAL PURPOSE COST CENTERS						80. 0
	8000 MALPRACTICE PREMIUMS & PAID LOSSES						
	8100 I NTEREST EXPENSE 8200 UTI LI ZATI ON REVIEW						81.0 82.0
			r.		0	0	
	8400 OTHER SPECIAL PURPOSE COST	0	C		0 0 0 0		
	SUBTOTALS (sum of lines 1-84)	0	Ĺ	1	0 0	0	89.0
	ONREIMBURSABLE COST CENTERS		(0		
1	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		()	0 0		
	9100 BARBER AND BEAUTY SHOP	0			-	0	
	9200 PHYSI CLANS PRI VATE OFFI CES	0	(1	0 0	0	
	9300 NONPALD WORKERS	0	(1	0 0	0	
	9400 PATIENTS LAUNDRY	0	0	1	0 0	0	
	9500 OTHER NON REIMBURSABLE COST	0	C	י	0 0	0	
. 00	Cross Foot Adjustments				0 0	0	
. 00	Negative Cost Centers	0	C		0 0	0	
D. 00	TOTAL	0	C)	0 0	I 0	100. (

	Financial Systems Co ATION OF CAPITAL RELATED COSTS	ONTINUING CARE A		No.: 315523	Period:	worksheet B	
					From 01/01/2021 To 12/31/2021		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		9.00	SUPPLY 10.00	11.00	LI BRARY 12.00	13.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00 5.00	00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS						4.00 5.00
6.00	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	0					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0				10.00
11.00		0	0		0		11.00
12.00 13.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	0			0	12.00 13.00
13.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			0	1
15.00	01500 OTHER GENERAL SERVICE COST	0	0		0 0	-	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	0		0 0		
31.00	03100 NURSING FACILITY	0	0		0 0	-	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	40.00
40.00	04100 LABORATORY	0	0			-	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0)	0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 0	0	
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	
46.00		0	0		0 0	0	
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0)	0 0	0	1
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTER	0	0)	0 0	0	52.00
(0.00	OUTPATIENT SERVICE COST CENTERS						
60.00 63.00	06000 CLINIC 06300 OTHER OUTPATIENT SERVICE COST	0	0 0				
03.00	OTHER REIMBURSABLE COST CENTERS	0	0	1	0 0	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	0)	0 0	0	70.00
71.00	07100 AMBULANCE	0	0)	0 0	0	71.00
74.00	07400 OTHER REIMBURSABLE COST	0	0)	0 0	0	74.00
~~ ~~	SPECIAL PURPOSE COST CENTERS	1		1			
80. 00 81. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE						80.00 81.00
82.00	08200 UTI LI ZATI ON REVI EW						81.00
84.00	08400 OTHER SPECIAL PURPOSE COST	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	0		0 0		1
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0		
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0			0	
93.00 94.00	09400 PATIENTS LAUNDRY	0	0			0	1
95.00	09500 OTHER NON REIMBURSABLE COST	0	0		0 0	0	
98.00	Cross Foot Adjustments	0	0		0		98.00
99.00	Negative Cost Centers	0	0		0 0		99.00
100.00	D TOTAL	0	0	1	0 0	0	100.00

Heal th	Financial Systems CC	ONTINUING CARE	AT LANT	ERN HILL	-	In Lie	u of Form CMS-:	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		F	Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 9/7/2022 1:57	
				GENERAL				
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	C	RVICE OST	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15	5.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	Т	1					
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT							1.00 2.00
3.00	00300 EMPLOYEE BENEFITS							3.00
4.00 5.00	00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS							4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE							6.00
7.00	00700 HOUSEKEEPING							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 12.00								11.00
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE							12.00 13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	C						14.00
15.00	01500 OTHER GENERAL SERVICE COST			0				15.00
	I NPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 SKILLED NURSING FACILITY	C		0	1, 748, 7		1, 748, 790	
	03100 NURSING FACILITY	C		0		0 0	0	
33.00	O3300 OTHER LONG TERM CARE	C)	0		0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	C		0		0 0	0	40.00
	04100 LABORATORY			0		0 0	0	
42.00	04200 I NTRAVENOUS THERAPY	C	þ	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	C		0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	C	D	0		0 0	0	
45.00	04500 OCCUPATI ONAL THERAPY	C	2	0		0 0	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY			0		0 0	0	46.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			0			0	
49.00	04900 DRUGS CHARGED TO PATIENTS		Ď	0		0 0	0	
	05000 DENTAL CARE - TITLE XIX ONLY	C	þ	0		0 0	0	
51.00	05100 SUPPORT SURFACES	C	D	0		0 0	0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTER	C)	0		0 0	0	52.00
10.00	OUTPATIENT SERVICE COST CENTERS			ō			0	1 (0.00
60.00 63.00	06000 CLINIC 06300 OTHER OUTPATIENT SERVICE COST			0		0 0 0 0	0	
03.00	OTHER REIMBURSABLE COST CENTERS		<u>/</u>	0		0 0	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	C		0		0 0	0	70.00
	07100 AMBULANCE	C	þ	0		0 0	0	71.00
74.00	07400 OTHER REIMBURSABLE COST	C		0		0 0	0	74.00
	SPECIAL PURPOSE COST CENTERS	1						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW							81.00 82.00
84.00	08400 OTHER SPECIAL PURPOSE COST		b	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	C		0	1, 748, 7	90 0	1, 748, 790	
	NONREI MBURSABLE COST CENTERS							
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C		0		0 0	0	
	09100 BARBER AND BEAUTY SHOP	C	2	0		0 0	0	
	09200 PHYSI CLANS PRI VATE OFFI CES		2	0		0 0	0	•
93.00 94.00	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY			0			0	
94.00 95.00	09500 OTHER NON REIMBURSABLE COST		ó	0	19, 945, 4	85 0	19, 945, 485	
98.00	Cross Foot Adjustments			0	17, 743, 4	0 0	0	
99.00	Negative Cost Centers		þ	0		0 0	0	
100.00	TOTAL	C)	0	21, 694, 2	75 0	21, 694, 275	100.00

Heal th	Financial Systems CO	NTINUING CARE /	AT LANTERN HILL	_	In Lie	u of Form CMS-2	2540-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre	
		CAPITAL REL	LATED COSTS			9/7/2022 1:57	pm
			LATED COSTS				
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconci I i ati on		
		FIXTURES (SQUARE FEET)	EQUI PMENT (SQUARE FEET)	BENEFITS (GROSS		& GENERAL (ACCUM. COST)	
			(SCOARE TEET)	SALARI ES)		(ACCOM. COST)	
		1.00	2.00	3.00	4A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	140, 763					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	140,703	140, 763				2.00
3.00	00300 EMPLOYEE BENEFITS	0	0	1	1		3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	0	0	1, 333, 70		50, 073, 278	4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0		713, 30		2, 017, 235 0	5.00 6.00
7.00	00700 HOUSEKEEPI NG	0	0		0 0	0	7.00
8.00	00800 DI ETARY	0	0	191, 60	1 0	256, 730	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0				0	10.00 11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	12.00
	01300 SOCIAL SERVICE	0	0		0 0	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 OTHER GENERAL SERVICE COST	0	0	207 75	0 0	0	14.00
15.00	INPATIENT ROUTINE SERVICE COST	0	0	397, 75	7 0	655, 683	15.00
30.00	03000 SKILLED NURSING FACILITY	11, 347	11, 347	3, 029, 66	4 0	6, 921, 918	30.00
	03100 NURSING FACILITY	0			0 0	0	31.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 0	0	33.00
40.00	04000 RADI OLOGY	0	0		0 0	22, 409	40.00
41.00	04100 LABORATORY	0	0		0 0	29, 942	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0		0 0	14, 145	
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0				0 129, 567	43.00 44.00
	04500 OCCUPATI ONAL THERAPY	0	0		0 0	123, 983	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	58, 251	46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0 22, 235	47.00 48.00
48.00	04900 DRUGS CHARGED TO PATIENTS	0			0 0	84, 985	48.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0)	0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTER OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	52.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
	06300 OTHER OUTPATIENT SERVICE COST	0			0 0	0	
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0 0 0 0	0	70.00 71.00
	07400 OTHER REIMBURSABLE COST	0	-		0 0		
	SPECIAL PURPOSE COST CENTERS	1	1	1			
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 82.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81.00 82.00
84.00	08400 OTHER SPECIAL PURPOSE COST	0	0		0 0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	11, 347	11, 347	5, 666, 03	0 -2, 008, 100	10, 337, 083	89.00
90.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
	09300 NONPALD WORKERS	0	0		0 0	0	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NON REIMBURSABLE COST	0 129, 416	129, 416	5, 425, 17	1 0	0 39, 736, 195	94.00 95.00
98.00 98.00	Cross Foot Adjustments	127,410		0, 20, 17		57,750,175	98.00 98.00
99.00	Negative Cost Centers						99.00
102.00		20, 863, 093	831, 182	3, 350, 54	1	2, 008, 100	102.00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	148. 214325	5. 904833	0. 30209	0	0. 040103	103.00
104.00	Cost to be allocated (per Wkst. B,				0		104.00
105 05	Part II)					0.00005-	105 00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.00000	U	0.00000	105.00
		I	1	I	I	I	1

	Financial Systems CC LLOCATION - STATISTICAL BASIS	ONTINUING CARE			In Lie Period:	u of Form CMS-2 Worksheet B-1	
CUSTA	LLUCATION - STATISTICAL DASIS		Provider	F	rom 01/01/2021 o 12/31/2021	Date/Time Pre	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG		9/7/2022 1:57 NURSI NG	
	cost center bescription	OPERATI ON,	LINEN SERVICE	(HOURS OF	(MEALS SERVED)		
		MALNT. &	(POUNDS OF	SERVI CE)			
		REPAIRS (SQUARE FEET)	LAUNDRY)			(DIRECT NRSING HRS)	
		5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		1				1.00
2.00	00200 CAP REL COSTS - BEDGS & FIXTORES						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	140, 763	0				5.00
7.00	00700 HOUSEKEEPING	0	0	0)		7.00
8.00	00800 DI ETARY	0	0	0	243, 195		8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9.00
	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0				0	10.00
	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	12.00
13.00	01300 SOCIAL SERVICE	0	0	C	0 0	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	-	0	14.00
15.00	01500 OTHER GENERAL SERVICE COST	0	0		0 0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	11, 347	0	0	37, 179	0	30.00
	03100 NURSING FACILITY	0				0	
33.00	03300 OTHER LONG TERM CARE	0	0	(0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0		0	0	40.00
	04100 LABORATORY				-	0	40.00
	04200 I NTRAVENOUS THERAPY	0	0	C	0	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0	C	0 0	0	43.00
	04400 PHYSI CAL THERAPY	0	0		0	0	44.00
	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY					0	45.00
	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(c	0 0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0				0	50.00
	05200 OTHER ANCI LLARY SERVICE COST CENTER		-		-	0	52.00
	OUTPATIENT SERVICE COST CENTERS	-				-	
	06000 CLINIC	0				0	
63.00	06300 OTHER OUTPATIENT SERVICE COST OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	(0	0	70.00
	07100 AMBULANCE	0	0	C	0	0	1
74.00	07400 OTHER REIMBURSABLE COST	0	00		00	0	74.00
00 00	SPECIAL PURPOSE COST CENTERS	1	1		1		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
	08200 UTI LI ZATI ON REVI EW						82.00
	08400 OTHER SPECIAL PURPOSE COST	0	i i	C		0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	11, 347	0		37, 179	0	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP		0		-	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	1
	09300 NONPALD WORKERS	0	0	0	0	0	93.00
	09400 PATIENTS LAUNDRY 09500 OTHER NON REIMBURSABLE COST	129, 416	0		0 0 206, 016	0	94.00 95.00
93.00 98.00	Cross Foot Adjustments	127,410			200,010	0	93.00
99.00	Negative Cost Centers						99.00
102.00		2, 098, 132	0	C	267, 026	0	102.00
103.00	Part I)	14 005400	0. 000000	0.000000	1 007001	0.00000	102 00
103.00		14. 905423	0.00000	0.00000	1.097991		103.00
104.00 105.00	Part II)	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	

<u>Heal th</u> I	Financial Systems C	ONTINUING CARE A	AT LANTERN HILL		In Lie	u of Form CMS-2	2540-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2021	Worksheet B-1	
					o 12/31/2021	Date/Time Pre	pared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	9/7/2022 1:57 NURSI NG AND	pm
	cost center bescription	SERVICES &	(COSTED	RECORDS &	SUCIAL SERVICE	ALLI ED HEALTH	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	EDUCATI ON	
		(COSTED REQUIS.)		(TIME SPENT)		(ASSI GNED TI ME)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
	DO100 CAP REL COSTS - BLDGS & FIXTURES						1.00
	DO200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00 3.00
	DO400 ADMINI STRATI VE & GENERAL						4.00
	DO500 PLANT OPERATION, MAINT. & REPAIRS						5.00
	DO600 LAUNDRY & LINEN SERVICE						6.00
	DO700 HOUSEKEEPI NG						7.00
	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8.00 9.00
	01000 CENTRAL SERVICES & SUPPLY	0					10.00
	D1100 PHARMACY	0	0				11.00
	01200 MEDICAL RECORDS & LIBRARY	0	0	0			12.00
	01300 SOCIAL SERVICE	0	0	0	0	0	13.00
	D1400 NURSING AND ALLIED HEALTH EDUCATION D1500 OTHER GENERAL SERVICE COST	0	0	0	0	0	14.00 15.00
	NPATIENT ROUTINE SERVICE COST CENTERS		0	0	0		15.00
	03000 SKILLED NURSING FACILITY	0	0	0	0	0	30.00
	D3100 NURSING FACILITY	0	0	0		0	31.00
	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	40.00
	04100 LABORATORY	0	0	0		0	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
	04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0	0	45.00 46.00
	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
	D4900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
	D5000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
	D5100 SUPPORT SURFACES D5200 OTHER ANCI LLARY SERVI CE COST CENTER	0	0	0		0	51.00 52.00
-	DUTPATIENT SERVICE COST CENTERS		0	0			02.00
	06000 CLI NI C	0		0		0	60.00
	06300 OTHER OUTPATIENT SERVICE COST	0	0	0	0	0	63.00
	DTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	70.00
	D7100 AMBULANCE	0	0	0		0	
	07400 OTHER REIMBURSABLE COST	0	0	0	0		74.00
S	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81.00 82.00
	08400 OTHER SPECIAL PURPOSE COST	0	0	0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	0	0		0	89.00
	NONREI MBURSABLE COST CENTERS			ľ	,		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	-	0	91.00 92.00
	09300 NONPAID WORKERS	0	0	0	0	0	93.00
	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
	09500 OTHER NON REIMBURSABLE COST	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments						98.00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	0	0	_	_	0	99.00 102.00
102.00	Part I)		0			0	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	
104.00	Cost to be allocated (per Wkst. B,	0	0	0	0	0	104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0.000000	105 00
		0.00000	0.00000		0.000000	0.00000	
'							

COST A	Financial Systems Co LLOCATION - STATISTICAL BASIS	ONTINUING CARE AT	Provi der No.: 315523	In Lieu of Form CMS Period: Worksheet B From 01/01/2021 To 12/31/2021 Date/Time P	-1
				To 12/31/2021 Date/Time P 9/7/2022 1:	
	Cost Center Description	OTHER GENERAL SERVICE COST (PATIENT DAYS)			
		15.00			_
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT				2.00
3.00	00300 EMPLOYEE BENEFITS				3.00
4.00	00400 ADMINISTRATIVE & GENERAL				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00	00600 LAUNDRY & LINEN SERVICE				6.00
7.00	00700 HOUSEKEEPING				7.00
8.00					8.00
9.00 10.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY				9.00
11.00	01100 PHARMACY				11.00
	01200 MEDICAL RECORDS & LI BRARY				12.00
	01300 SOCIAL SERVICE				13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION				14.00
15.00	01500 OTHER GENERAL SERVICE COST	187, 477			15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 SKILLED NURSING FACILITY	12, 393			30.00
	03100 NURSING FACILITY	0			31.00
33.00	O3300 OTHER LONG TERM CARE	0			33.00
10.00	ANCI LLARY SERVICE COST CENTERS	0			
40.00	04000 RADI OLOGY	0			40.00
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0			41.00
42.00	04300 OXYGEN (INHALATION) THERAPY	0			42.00
	04400 PHYSI CAL THERAPY	0			44.00
	04500 OCCUPATI ONAL THERAPY	0			45.00
	04600 SPEECH PATHOLOGY	0			46.00
47.00	04700 ELECTROCARDI OLOGY	0			47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48.00
	04900 DRUGS CHARGED TO PATIENTS	0			49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			50.00
	05100 SUPPORT SURFACES	0			51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTER OUTPATIENT SERVICE COST CENTERS	0			52.00
60.00	06000 CLINIC	0			60.00
63.00	06300 OTHER OUTPATIENT SERVICE COST	0			63.00
00.00	OTHER REIMBURSABLE COST CENTERS				
70.00	07000 HOME HEALTH AGENCY COST	0			70.00
71.00	07100 AMBULANCE	0			71.00
74.00	07400 OTHER REI MBURSABLE COST	0			74.00
~~ ~~	SPECIAL PURPOSE COST CENTERS				0.0.0
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES				80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW				81.00 82.00
82.00 84.00	08200 OTHER SPECIAL PURPOSE COST	0			82.00
89.00	SUBTOTALS (sum of lines 1-84)	12, 393			89.00
_ /. 00	NONREI MBURSABLE COST CENTERS	12,070			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90.00
91.00	09100 BARBER AND BEAUTY SHOP	0			91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0			92.00
93.00	09300 NONPAI D WORKERS	0			93.00
94.00	09400 PATIENTS LAUNDRY	0			94.00
95.00	09500 OTHER NON REIMBURSABLE COST	175, 084			95.00
98.00	Cross Foot Adjustments				98.00
99.00	Negative Cost Centers	(01.070			99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	681, 978			102.00
103.00		3. 637662			103.00
103.00		0			103.00
	Part II)				
105.00		0. 000000			105.00
					1

Health Financial Systems CONTINUING CARE AT LA	NTERN HILL		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der		Period:	Worksheet C	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 9/7/2022 1:57	
Cost Center Description		Total (from		Ratio (col. 1	
		Wkst. B, Pt I		di vi ded by	
		col. 18)		col. 2	
		1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS					10.00
40. 00 04000 RADI OLOGY		23, 30			
41.00 O4100 LABORATORY		31, 14			
42. 00 04200 I NTRAVENOUS THERAPY		14, 71	2 21, 387		
43.00 04300 0XYGEN (INHALATION) THERAPY			0 0	0.00000	
44. 00 04400 PHYSI CAL THERAPY		134, 76			
45. 00 04500 OCCUPATI ONAL THERAPY		128, 95			
46.00 04600 SPEECH PATHOLOGY		60, 58	7 139, 344		
47. 00 04700 ELECTROCARDI OLOGY			0 0	0.00000	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		23, 12		6. 182037	
49.00 04900 DRUGS CHARGED TO PATIENTS		88, 39	3 87, 199		•
50.00 05000 DENTAL CARE - TITLE XIX ONLY			0 0	0.00000	•
51.00 05100 SUPPORT SURFACES			0 0	0.00000	•
52. 00 05200 OTHER ANCI LLARY SERVICE COST CENTER			0 0	0.00000	52.00
OUTPATIENT SERVICE COST CENTERS					1 / 2 . 2 2
			0 0	0.00000	•
63. 00 06300 OTHER OUTPATIENT SERVICE COST			0	0.00000	•
71.00 07100 AMBULANCE		50/ 00	0 011 007	0.00000	
100. 00 Total		504, 98	8 811, 827		100. 00

Health Financial Systems	CONTINUING CARE	AT LANTERN HILL	-	In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021		
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pr	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTP	ATIENT COST					
ANCILLARY SERVICE COST CENTERS		-				
40. 00 04000 RADI OLOGY	1. 341313			0 16, 156		10100
41. 00 04100 LABORATORY	0. 930837			0 7,851		1
42.00 04200 INTRAVENOUS THERAPY	0. 687895	8, 849		0 6, 087	0	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY	0. 000000			0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0. 514327	167, 709		0 86, 257	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 521443	169, 863		0 88, 574	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 434802	81, 469		0 35, 423	0	46.00
47.00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	6. 182037	0		0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1.013693	67, 020		0 67, 938	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTER	0. 000000	0		0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
63.00 06300 OTHER OUTPATIENT SERVICE COST	0. 000000	0		0 0	0	63.00
71.00 07100 AMBULANCE (2)	0.000000			0	0	1
100.00 Total (Sum of lines 40 - 71)		515, 389		0 308, 286	0	100.00
(1) Far title Ward VIV was aslympt 1. 2 and 4 a						

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

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

Health Financial Systems CC	NTINUING CARE A	T LANTERN HILI	_	In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021	9/7/2022 1:57	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description				racificy		
					1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00 Drugs charged to patients - ratio of co	ost to charges ((From Workshee	t C, column 3	, line 49)	1.013693	1.00
2.00 Program vaccine charges (From your reco					0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	iders, transf	er this amoun	t to Worksheet	0	3.00
E, Part I, line 18)	ii		i			
Cost Center Description	Total Cost	Nursing &	Ratio of		Part A Nursing	
	(From Wkst. B,			Cost (From	& Allied	
		(From Wkst. B,				
	18	Part I, Col. 14)	Costs to Tota Costs - Part		for Pass Through (Col.	
		14)	(Col. 2 / Col		3 x Col. 4)	
					J X COI. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS						
ANCI LLARY SERVI CE COST CENTERS						
40. 00 04000 RADI OLOGY	23, 308	0	0.0000	0 16, 156	0	40.00
41.00 04100 LABORATORY	31, 143	0	0.0000	7, 851	0	41.00
42.00 04200 I NTRAVENOUS THERAPY	14, 712	C	0.0000	6, 087	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	C	0.0000		0	43.00
44. 00 04400 PHYSI CAL THERAPY	134, 763	0	0.0000		0	44.00
45.00 04500 OCCUPATI ONAL THERAPY	128, 955	0	0.0000		0	45.00
46.00 04600 SPEECH PATHOLOGY	60, 587	C	0.0000		0	46.00
47.00 04700 ELECTROCARDI OLOGY	0	C	0.0000		0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	23, 127	0	0.0000		0	48.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	88, 393	0	0.0000		0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.0000		0	50.00
51.00 05100 SUPPORT SURFACES	0	0	0.0000		0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTER 100.00 Total (Sum of Lines 40 - 52)	E04 000	0	0.0000		0	52.00 100.00
100.00 [10tal (Sum of Times 40 - 52)	504, 988	U	1	308, 286	0	100.00

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 9/7/2022 1:57	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	INPATIENT DAYS				1
1.00	Inpatient days including private room days			12, 393	1 1.00
2.00	Private room days			0	1
3.00	Inpatient days including private room days applicable to the	e Program		2, 263	3.00
4.00	Medically necessary private room days applicable to the Pro-		0		
5.00	Total general inpatient routine service cost		7, 454, 544	5.00	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				1
5.00	General inpatient routine service charges			5, 420, 105	6.00
7.00	General inpatient routine service cost/charge ratio (Line		1.375350	7.00	
3.00	Enter private room charges from your records		0		
9.00	Average private room per diem charge (Private room charges	room days, line	0.00	9.0	
	2)				
10.00	Enter semi-private room charges from your records		0		
11.00	Average semi-private room per diem charge (Semi-private ro	ed by	0.00	11.00	
	semi-private room days)				
12.00	Average per diem private room charge differential (Line 9 m				12.0
13.00	Average per diem private room cost differential (Line 7 tim				13.0
14.00 15.00	Private room cost differential adjustment (Line 2 times line		minus line 14)	0	
15.00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus rine 14)	7, 454, 544	1 15.0
16.00	Adjusted general inpatient service cost per diem (Line 15	divided by Line 1)		601.51	1 16 0
17.00	Program routine service cost (Line 3 times line 16)	divided by interio		1, 361, 217	
18.00	Medically necessary private room cost applicable to program	(line 4 times line 13)		1, 301, 217	
19.00	Total program general inpatient routine service cost (Line			1, 361, 217	
20.00	Capital related cost allocated to inpatient routine service		t II column 18.	1, 748, 790	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			.,,	
21.00	Per diem capital related costs (Line 20 divided by line 1)			141.11	21.0
22.00	Program capital related cost (Line 3 times line 21)			319, 332	
23.00	Inpatient routine service cost (Line 19 minus line 22)			1, 041, 885	
24.00	Aggregate charges to beneficiaries for excess costs (From	provider records)		0	24.0
25.00	Total program routine service costs for comparison to the c	ost limitation (Line 23 mi	nus line 24)	1, 041, 885	25.0
26.00	Enter the per diem limitation (1)				26.0
27.00	Inpatient routine service cost limitation (Line 3 times the				27.0
28.00			line 27)		28.0
	(Transfer to Worksheet E, Part II, line 4) (See instruction:	5)			1

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	12, 393	1.00
2.00	Program inpatient days (see instructions)	2, 263	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 182603	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Pre	
		Title XVIII	Skilled Nursing	9/7/2022 1:57 PPS	pm
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIM	BURSEMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)			1, 472, 013	1.00
2.00	Nursing and Allied Health Education Activities (pass throug	h payments)		0	2.0
3.00	Subtotal (Sum of lines 1 and 2)			1, 472, 013	3.0
1.00	Primary payor amounts			0	4.0
5.00	Coinsurance			131, 705	5.0
5.00	Allowable bad debts (From your records)			0	6.0
7.00	Allowable Bad debts for dual eligible beneficiaries (See in	structions)		0	7.0
3.00	Adjusted reimbursable bad debts. (See instructions)			0	8.0
9.00	Recovery of bad debts - for statistical records only			0	9.0
0.00	Utilization review			0	10.0
1.00	Subtotal (See instructions)			1, 340, 308	11. C
2.00	Interim payments (See instructions)			1, 340, 308	12.0
3.00	Tentati ve adjustment			0	13.0
4.00	OTHER adjustment (See instructions)			0	14.0
4.50	Demonstration payment adjustment amount before sequestratio	n		0	14.5
4.55	Demonstration payment adjustment amount after sequestration	l .		0	14.5
4.75	Sequestration for non-claims based amounts (see instruction	s)		0	14.7
4.99	Sequestration amount (see instructions)			0	14.9
5.00	Balance due provider/program (see Instructions)			0	15.0
6.00	Protested amounts (Nonallowable cost report items in accord			0	16. C
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LES	SER OF COST OR CHARGES - T	ITLE XVIII ONLY		
7.00	Ancillary services Part B			0	17.0
8.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.0
9.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.0
0. 00	Medicare Part B ancillary charges (See instructions)			0	20.0
1.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.0
2.00	Primary payor amounts			0	22.0
3.00	Coinsurance and deductibles			0	23.0
4.00	Allowable bad debts (From your records)			0	24.0
4. 01	Allowable Bad debts for dual eligible beneficiaries (see in	istructions)		0	24.0
4. 02	Adjusted reimbursable bad debts (see instructions)			0	24.0
5.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.0
6.00	Interim payments (See instructions)			0	26.0
7.00	Tentative adjustment			0	27.0
28.00	Other Adjustments (See instructions) Specify			0	28.0
28.50	Demonstration payment adjustment amount before sequestratio			0	28.5
28.55	Demonstration payment adjustment amount after sequestration			0	28.5
28.99	Sequestration amount (see instructions)			0	28.9
29.00	Balance due provider/program (see instructions)			0	29. C

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Pre 9/7/2022 1:57	parec
		Ti tl	e XVIII	Skilled Nursing Facility		
		Inpatier	nt Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		1, 340, 3	08 0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER		1	0	0	3.
02	ADJUSTIMENTS TO FROM DER			0	0	
03				0	0	
04				0	0	3.
)5				0	0	3
~	Provider to Program ADJUSTMENTS TO PROGRAM		T	0	0	1,
0	ADJUSTMENTS TU PROGRAM			0	0	
52				0	0	
3				0	0	
54				0	0	
9	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)			0	0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		1, 340, 3	08	0	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1			5
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		Т		1	
)1)2	TENTATI VE TO PROVI DER			0	0	
12 13				0	0	
5	Provider to Program		1	0	0	1 7
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
2				0	0	
9	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER		1	0	0	6
)2	PROVIDER TO PROGRAM			0	0	
0	Total Medicare program liability (see instructions)		1, 340, 3		0	7
			Contra	actor Name	Contractor Number	
				1.00	2.00	

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

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der	No.: 315523	Period: From 01/01/2021 To 12/31/2021	Worksheet G Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	9/7/2022 1:57 Plant Fund	
		1.00	Purpose Fun 2.00	d 3.00	4.00	-
	Assets	1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
)	Cash on hand and in banks	9, 499, 556		0 0 0 0	0	
)	Temporary investments Notes receivable	0		0 0	0	
5	Accounts receivable	505, 365		0 0	0	
)	Other receivables	7, 967, 567		0 0	0	1
D	Less: allowances for uncollectible notes and accounts	0		0 0	0	0
)	recei vabl e I nventory	276, 151		0 0	0	
5	Prepaid expenses	71, 545		0 0	0	
)	Other current assets	0		0 0	0	0
00	Due from other funds	0		0 0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	18, 320, 184		0 0	0	1
00	FI XED ASSETS Land	0		0 0	0	12
00	Land improvements	36, 195		0 0	0	
00	Less: Accumulated depreciation	-2, 377		0 0	0	
00	Buildings	232, 523, 947		0 0	0	
00 00	Less Accumulated depreciation Leasehold improvements	-21, 512, 684 1, 108, 905		0 0	0	
00	Less: Accumulated Amortization	-390, 813		0 0	0	
00	Fixed equipment	6, 241, 006		0 0	0	
00	Less: Accumulated depreciation	-4, 412, 128		0 0	0	
00	Automobiles and trucks	277, 695		0 0	0	
00 00	Less: Accumulated depreciation Major movable equipment	-186, 598 491, 697		0 0 0 0	0	
00	Less: Accumulated depreciation	-136, 973		0 0	0	
00	Minor equipment - Depreciable	0		0 0	0	
00	Minor equipment nondepreciable	0		0 0	0	
00	Other fixed assets	0		0 0	0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	214, 037, 872		0 0	0	2
00	Investments	1, 291, 737		0 0	0	2
00	Deposits on Leases	0		0 0	0	3
00	Due from owners/officers	0		0 0	0	
00 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	231, 016, 099 232, 307, 836		0 0 0 0	0	
00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	464, 665, 892		0 0	0	
	Liabilities and Fund Balances					
	CURRENT LI ABI LI TI ES	L	1		-	
00 00	Accounts payable Salaries, wages, and fees payable	835, 821 898, 234		0 0 0 0	0	
00	Payroll taxes payable	210, 234		0 0		
00	Notes & Loans payable (Short term)	4, 553, 742		0 0	0	
00	Deferred income	0		0 0	0	-
00	Accel erated payments	0		0		40
00 00	Due to other funds Other current liabilities	16, 787, 607		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	23, 285, 640		0 0	0	
	LONG TERM LIABILITIES					
00	Mortgage payable	0		0 0	0	
00	Notes payable	235, 486, 853		0 0	0	
00 00	Unsecured Loans Loans from owners:	0		0 0	0	
00	Other long term liabilities	229, 809, 949		0 0	0	
00	OTHER (SPECIFY)	0		0 0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	465, 296, 802		0 0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	488, 582, 442		0 0	0	5
00	CAPI TAL ACCOUNTS General fund balance	-23, 916, 550				5
00	Specific purpose fund			0		5
00	Donor created - endowment fund balance - restricted			0		5
00	Donor created - endowment fund balance - unrestricted			0		5
00	Governing body created - endowment fund balance			0	_	5
00 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-23, 916, 550		0 0	0	-
00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	464, 665, 892		0 0	0	60

		NTINUING CARE A					eu of Form CMS		540-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provi d	er No.: 315523		eriod: rom 01/01/2021 p 12/31/2021	Worksheet G- Date/Time Pr 9/7/2022 1:5	гер	
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fur	nd	
								+	
		1.00	2.00	3.00		4.00	5.00		
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 88.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17)		-19, 468, : -4, 448, : -23, 916, !	205 550 0	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0		000000000000000000000000000000000000000	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-23, 916, !	550		0			19.00
		Endowment Fund	PI	ant Fund			L		
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0	7.00	0 0 0 0	0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0 0		0 0 0 0 0	0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Health Financial Systems CONTINUING CARE AT LANTERN HILL In Lieu of Form CMS-2540-1								
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315523	Period: From 01/01/2 To 12/31/2	2021	Worksheet G-2 Parts I-II Date/Time Pre 9/7/2022 1:57	pared:	
	Cost Center Description		I npati ent	Outpati e	nt	Total		
			1.00	2.00		3.00		
	PART I - PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY		5, 420, 105		5, 420, 105	1.00		
2.00	NURSING FACILITY		0		0	2.00		
3.00	CF/IID		0		0	3.00		
4.00	OTHER LONG TERM CARE		0		0	4.00		
5.00	Total general inpatient care services (Sum of lines 1 - 4)		5, 420, 1	05		5, 420, 105	5.00	
	All Other Care Services							
6.00	ANCI LLARY SERVI CES		811, 8	27	0	811, 827	6.00	
7.00					0	0	7.00	
8.00	HOME HEALTH AGENCY COST				0	0	8.00	
9.00	AMBULANCE				0	0	9.00	
10,00	RURAL HEALTH CLINIC				0	0	10.00	
10, 10	FQHC				0	0	10.10	
11.00	СМНС				0	0	11.00	
12.00	HOSPI CE			0	0	0	12.00	
13.00	OTHER (SPECI FY)			0	0	0	13.00	
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	6, 231, 9	32	0	6, 231, 932		
	Worksheet G-3, Line 1)		0,201,7	02	0	0/201//02	1.1.00	
Cost Center Description								
				1.00		2.00		
	PART II - OPERATING EXPENSES							
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					53, 292, 829	1.00	
2.00	Add (Specify)				0	0072727027	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	8.00	
9.00	Deduct (Specify)				0	0	9.00	
10.00					0		10.00	
11.00					0		11.00	
12.00					0		12.00	
13.00					0		13.00	
	Total Deductions (Sum of Lines 9 - 13)				0	0	14.00	
15.00 Total Operating Expenses (Sum of Lines 1 and 8, minus line 14)					53, 292, 829			
15.00	Trotal operating Expenses (Sum of Thes Fand 6, Influs The 14)			I		55, 272, 027	15.00	

Health Financial Systems CONTINUING CARE AT LANTERN HILL In Lieu of Form CMS-2540-10								
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315523	Peri od:	Worksheet G-3				
			From 01/01/2021					
			To 12/31/2021	Date/Time Pre				
				9/7/2022 1:57	pm			
				1.00				
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		6, 231, 932	1.00			
2.00	Less: contractual allowances and discounts on patients accounts				2.00			
3.00	Net patient revenues (Line 1 minus line 2)				3.00			
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)				4.00			
5.00	Net income from service to patients (Line 3 minus 4)			-47, 364, 815	5.00			
	Other income:							
6.00	Contributions, donations, bequests, etc			289, 145	6.00			
7.00	Income from investments			10, 962, 981	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			80, 446	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 th	an patients		0	16.00			
17.00	Revenue from sale of drugs to other than patients			0	17.00			
18.00	Revenue from sale of medical records and abstracts			36	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	MI SCELLANEOUS REVENUE			7, 350				
24.01	ASSISTED, INDEPENDENT & OTHER SVC			30, 706, 616				
24.02	OTHER SERVICES			201, 986				
24.03	AL & IL DINING			171, 152				
24.04	HOUSEKEEPING SERVICES			190				
24.05	SECURI TY SERVI CES			18, 325				
24.06	TRANSPORTATION SERVICES			19, 482				
24.07				24, 195				
24.09	ACTIVITY & MEMBERSHIP FEES			15, 390				
24.11	MAINTENANCE FEES			21, 317				
24.50	COVI D-19 PHE Funding			397, 999				
25.00	Total other income (Sum of lines 6 - 24)			42, 916, 610				
26.00	Total (Line 5 plus line 25)			-4, 448, 205				
27.00	Other expenses (specify)			0	27.00			
28.00				0	28.00			
29.00	Tatal athen averages (Sum of Lines 27 20)			0	29.00			
30.00	Total other expenses (Sum of Lines 27 - 29) Net income (or Loss) for the period (Line 26 minus Line 30)			0 -4, 448, 205	30.00			
31.00	Iner income (or ross) for the period (time zo millings fille 30)			-4, 440, 205	31.00			