Health Financial Systems CONTINUING CARE AT SEABROOK VILLAGE In Lieu of Form CMS-2540-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315469 Worksheet S Parts I, II & III Peri od: From 01/01/2021 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 9/7/2022 1: 37 pm PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: Ti me: use only] Manually prepared cost report 2 0] If this is an amended report enter the number of times the provider resubmitted this cost report 3] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [2] Cost Report Status 6. Contractor No. 12001 (1) As Submitted use only 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN

9. NPR Date:

11. Contractor Vendor Code

for no utilization.

09/23/2022

10.[0]If line 4, column $\frac{1}{1}$ is "4": Enter number of times reopened

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

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

(3) Settled with audit

5. Date Received: 06/01/2022

(4) Reopened

(5) Amended

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 SEABROOK VILLAGE (315469) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	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
7. 10	SNF - BASED CORF I	0		0		7. 10
7.30	SNF - BASED OPT X	0		0		7. 30
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.

	ID NURSING FACILITY AND SKILLED NURSING FACILITY IX INDENTIFICATION DATA		Provi der No		Period: From 01/01, To 12/31,	/2021	Workshe Part I Date/Ti 9/7/202	me Pre	pared:
	1.00	2.00	Addross	3. 00					
00	Skilled Nursing Facility and Skilled Nursing F Street: 3002 ESSEX ROAD	O Box:	Address:						1.0
00		о вох. tate: NJ	Zi p Code: 07	7752					2. 0
00		BSA Code: 35154	Urban/Rural						3. 0
01		BSA Code: 33134 BSA Code:	UI Dali/ Kui ai	. 0					3.0
01			oonent Name	Provi der	Date	Payme	nt Syst	em (P	3.0
		00	Jones Hamo	CCN	Certi fi ed		0, or N		
						V	XVIII	XIX	1
			1.00	2.00	3. 00	4. 00	5. 00	6.00	
	SNF and SNF-Based Component Identification:								
00	SNF		NG CARE AT	315469	08/08/2001	N	P	0	4.0
		SEABROOK	VILLAGE						
00	Nursing Facility								5.0
00	ICF/IID	CEADDOOK	VILLAGE ODT	217002	12 /04 /2000	١,,		l N	6.0
00	SNF-Based HHA SNF-Based RHC	SEABROOK	VILLAGE OPT	317093	12/04/2008	N	P	N	7. 0
00	SNF-Based FOHC				1				9.0
00	SNF-Based CMHC								10.0
1. 00	SNF-Based OLTC				1				11. 0
2. 00	SNF-Based HOSPICE								12. 0
	SNF-Based CORF				1				13. 0
	SNF-Based OPT	OP REHAB	AGENCY AT	316702	08/08/2003				13. 1
		SEABROOK							
				<u> </u>	From:		To	:	
					1. 00		2. (00	
	Cost Reporting Period (mm/dd/yyyy)				01/01/2		12/31	/2021	14.0
5. 00	Type of Control (See Instructions)					2			15.0
						-	Y/		1
							1. (00	
	Type of Freestanding Skilled Nursing Facility				. 40 050			•	1, 0
o. 00	Is this a distinct part skilled nursing facili	ty that meets th	ie requirements	s set forth	in 42 CFR		N	l	16. 0
7 00	section 483.5?	ing facility tha	+ maata tha ma		oot forth				17. 0
. 00	Is this a composite distinct part skilled nurs 42 CFR section 483.5?	ing racifity tha	it lileets the re	equirements	set fortii	'''	N	ı	17.0
3 00	Are there any costs included in Worksheet A th	at resulted from	transactions	with relat	ed		Υ	,	18. 0
, 00	organizations as defined in CMS Pub. 15-1, cha						·		
	Miscellaneous Cost Reporting Information								1
9. 00	If this is a low Medicare utilization cost rep	ort, indicate wi	th a "Y", for	yes, or "N	l" for no.		N		19. 0
9. 01	If line 19 is yes, does this cost report meet			filing a	low Medicar	е	N	l	19.0
	utilization cost report, indicate with a "Y",	for yes, or "N"	for no.						1
	Depreciation - Enter the amount of depreciation	n reported in th	nis SNF for the	e method ir	ndi cated on	Li nes			
	Straight Line						14,	195, 748	1
	Declining Balance							(
	Sum of the Year's Digits Sum of line 20 through 22					-	1./	195, 748	1 0
	If depreciation is funded, enter the balance a	as of the end of	the period			-	14,		24.0
	Were there any disposal of capital assets duri			(Y/N)		1	Υ		25.0
5. 00	Was accelerated depreciation claimed on any as:				portina per	i od?			26.0
. 50	(Y/N)		any pri	5551 10	, y poi				
7. 00	Did you cease to participate in the Medicare p	rogram at end of	the period to	which thi	s cost repo	rt	N	I	27.0
	applies? (Y/N)	· ·	·		·				
3. 00	Was there a substantial decrease in health ins	urance proportic	n of allowable	e cost from	prior cost		N	I	28.0
	reports? (Y/N)						.	1	
							A Part B		4
	If this facility contains a rubit	io provide: +b	auglific- f	r on over	tion from th	1.00		3.00	
	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y"							1	
	exemption.	roi cacii compoi	ioni and type (o. Service	that qualifi	. 03 10	, the		
9. 00	Skilled Nursing Facility					N	N		29. 0
0.00	Nursing Facility					"	"	N	30.0
1.00	ICF/IID								31.0
2. 00	SNF-Based HHA					N	N		32.0
3. 00	SNF-Based RHC						N		33.0
1. 00	SNF-Based FQHC						N		34.0
5. 00	SNF-Based CMHC						N		35. C
	SNF-Based OLTC					L			36.0
6. 00					Y/N				
b. 00					1.00		2. (00	
	I				_				
	Is the skilled nursing facility located in a s			der as a SN	IF Y				37.0
7. 00	regardless of the level of care given for Title	es V & XIX patie	ents? (Y/N)	der as a SN					
. 00		es V & XIX patie insurance? (Y/N)	ents? (Y/N)	der as a SN	IF Y				37. (38. (39. (

Health Financial Systems CONTINUING CARE AT SEABROOK VILLAGE In L	eu of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315469 Period:	Worksheet S-2	
COMPLEX INDENTIFICATION DATA From 01/01/202		pared:
	9/7/2022 1: 37	
Premi ums Pai d Losses	Self Insurance	
1.00 2.00	3.00	
41.00 List malpractice premiums and paid losses: 0 0	0	41.00
	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 t	ne lines	
bel ow.		
45.00 Name: ERICKSON LIVING MANAGEMENT, LLC Contractor's Name: NOVITAS SOLUTIONS Contractor's Number: 12	001	45. 00
46.00 Street: 701 MAI DEN CHOICE LANE PO Box:		46. 00
47.00 City: CATONSVILLE State: MD Zip Code: 21	228	47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Pro	ovider N		Period: From 01/01/2021 To 12/31/2021 Y/N		epared:
					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	es enter in column 1,	"Y" for	Yes or "N"			
. 00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the heginal	na of th	no cost	N	I	1.00
. 00	reporting period? If column 1 is "Y", enter t instructions)	the date of the change	in colur	mn 2. (see			1.00
			-	1. 00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of			N	2.00	0.00	2. 00
3. 00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	ions, including manage , chain home offices, to the provider or it , or members of the bo	ement drug ts pard	Y			3. 00
	Total one man de l'energia			Y/N	Туре	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
1. 00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A" Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	for Audited, "C" for te copy or enter date	olic	Υ	A		4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If creconciliation.	revenues different fro		N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities						
6. 00 7. 00 8. 00	Column 1: Were costs claimed for Nursing Schollegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during	s? (Y/N) see instruction	ons.		N N N	N	6. 00 7. 00 8. 00
7. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instructions the cost reporting p	ons.		N		7. 00
7. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during	s? (Y/N) see instructions the cost reporting p	ons.		N	N Y/N 1. 00	7. 00
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7. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) see Bad Debts Is the provider seeking reimbursement for back	s? (Y/N) see instructions the cost reporting per instructions. I debts? (Y/N) see inst	ons. Deriod fo	or Nursing	N N	Y/N	7. 00 8. 00 9. 00
7. 00 3. 00 9. 00 0. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) see Bad Debts Is the provider seeking reimbursement for bactline 9 is "Y", did the provider's bad debtageriod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	s? (Y/N) see instruction the cost reporting page instructions. I debts? (Y/N) see instruction policy characterists.	ons. Deriod fo tructions	or Nursing s. Ing this cos	N N	Y/N 1.00	7. 00 8. 00 9. 00 10. 00
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Health Financial Systems	CONTINUING CARE AT	SEABROOK VILLA	AGE	In Lie	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND	Provi der		Peri od:	Worksheet S-2		
COMPLEX REIMBURSEMENT QUESTIO	NNAI RE			From 01/01/2021 Fo 12/31/2021	Part II Date/Time Pre	narod:
					9/7/2022 1: 37	_pm
		1.	00	2. (00	
Cost Report Preparer Co	ontact Information					
		JON		UNROE		19. 00
held by the cost repor	t preparer in columns 1, 2, and 3,					
respecti vel y.						
20.00 Enter the employer/com	pany name of the cost report	BKD, LLP				20. 00
preparer.						
		713-499-4600		JUNROE@BKD. COM		21. 00
report preparer in col	umns 1 and 2, respectively.					

respecti vel y.

preparer.

20.00

21.00

held by the cost report preparer in columns 1, 2, and 3,

Enter the telephone number and email address of the cost

Enter the employer/company name of the cost report

report preparer in columns 1 and 2, respectively.

Health Financial Systems In Lieu of Form CMS-2540-10 CONTINUING CARE AT SEABROOK VILLAGE SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315469 Peri od: Worksheet S-2 From 01/01/2021 To 12/31/2021 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 9/7/2022 1:37 pm Part B Date 4.00 PS&R Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to 04/25/2022 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 14.00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 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/position PARTNER 19.00

20.00

21.00

23.00 State

24. 00 Zi p

MD

21228

23.00

24.00

Worksheet S-2 Part V Date/Time Prepared: VOLUNTARY CONTACT INFORMATION Provi der No.: 315469 Peri od: From 01/01/2021 To 12/31/2021 9/7/2022 1:37 pm 1.00 Cost Report Preparer Contact Information First Name 1.00 1.00 2.00 Last Name 2.00 3.00 3.00 Title 4.00 Employer 4.00 5.00 Phone Number 5.00 6.00 E-mail Address 6.00 7.00 Department 7.00 Mailing Address 1 8.00 8.00 9.00 Mailing Address 2 9.00 10.00 Ci ty 10.00 11.00 State 11.00 12.00 12.00 Zip Officer or Administrator of Provider Contact Information 13.00 First Name Staci 13.00 Last Name 14.00 14.00 Henderson 15.00 Title 15.00 16.00 Employer 16.00 Phone Number 4104022347 17.00 17.00 18.00 E-mail Address Staci . Henderson@eri ckson. com 18.00 19.00 Department 19.00 20.00 Mailing Address 1 Dept: Central Accounting 20.00 21.00 Mailing Address 2 21.00 22. 00 Ci ty Baltimore 22.00 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Provi der No.: 315469

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

9/7/2022 1:37 pm Inpatient Days/Visits Title XVIII Number of Beds Bed Days Title V Title XIX Component Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 86 31, 390 3, 691 2, 421 1. 00 C NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 2, 174 0 4.00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 SNF-Based CORF 6.10 6. 10 6.30 SNF-Based OPT 6.30 7.00 HOSPI CE 7.00 Total (Sum of lines 1-7) 86 31, 390 5, 865 2, 421 8.00 8.00 Inpatient Days/Visits Di scharges Component 0ther Total Title V Title XVIII Title XIX 6.00 9.00 10.00 7.00 8.00 SKILLED NURSING FACILITY 1 00 12, 043 159 1 00 18, 155 2.00 NURSING FACILITY 0 2.00 3.00 ICF/IID 3.00 4.00 HOME HEALTH AGENCY COST 1, 198 4.00 3.372 5 00 Other Long Term Care 5 00 6.00 SNF-Based CMHC 6.00 SNF-Based CORF 6.10 6. 10 SNF-Based OPT 6.30 6.30 HOSPI CE 7.00 0 7.00 Total (Sum of lines 1-7) 13, 241 8.00 8.00 Stay Di scharges Average Length of Component 0ther Title V Title XVIII Title XIX Total 11.00 12.00 13.00 14.00 15.00 SKILLED NURSING FACILITY 189 356 0.00 302.63 1.00 23. 21 1.00 2.00 NURSING FACILITY 0.00 0.00 2.00 0 LCE/LLD 3.00 0 0.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 5.00 SNF-Based CMHC 6 00 6 00 6.10 SNF-Based CORF 6.10 6.30 SNF-Based OPT 6.30 7.00 HOSPI CE 0.00 0.00 0.00 7.00 302.63 Total (Sum of lines 1-7) 189 356 0 00 8.00 8.00 23.21 Average Length Admi ssi ons of Stay Title XVIII 0ther Component Total Title V Title XIX 16,00 17.00 19.00 20.00 18.00 SKILLED NURSING FACILITY 1.00 51.00 199 175 1 00 2.00 NURSING FACILITY 0.00 0 2.00 3.00 ICF/IID 0.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 5.00 Other Long Term Care 0.00 5.00 SNF-Based CMHC 6.00 6.00 SNF-Based CORF 6.10 6.10 SNF-Based OPT 6.30 6.30 7.00 HOSPI CE 0.00 0 7.00 51.00 199 175 8.00 Total (Sum of lines 1-7) 8.00 Full Time Equivalent Admi ssi ons Component Total Employees on Nonpai d Payrol I Workers 21.00 22.00 SKILLED NURSING FACILITY 1.00 379 100. 97 0.00 1. 00 NURSING FACILITY 2.00 0 0.00 0.00 2.00 3.00 ICF/IID 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 5.81 0.00 4.00 5.00 Other Long Term Care 0.00 0.00 5.00 SNF-Based CMHC 6.00 0.00 0.00 6.00 6.10 SNF-Based CORF 0.00 0.00 6.10 6.30 SNF-Based OPT 4.46 0.00 6.30 HOSPI CE 7.00 0.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 379 111.24 0.00 8.00

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315469

				'	0 12/31/2021	9/7/2022 1:37	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
4 00	SALARI ES	00 745 504		00 745 504	00/ 000 4/	04.00	4 00
1.00	Total salaries (See Instructions)	22, 745, 534	0	22, 745, 534			1.00
2.00	Physician salaries-Part A	0	0	0	0.00		2.00
3.00	Physician salaries-Part B	0	0	0	0.00		3. 00
4.00	Home office personnel	0	0	0	0.00		4. 00
5.00	Sum of lines 2 through 4	00 745 504	0	0 745 504	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	22, 745, 534	0	22, 745, 534			6. 00
7.00	Other Long Term Care	0	0	0	0.00		7. 00
8.00	HOME HEALTH AGENCY COST	526, 178	0	526, 178			8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
9. 10	CORF						9. 10
9. 20	OPT						9. 20
10.00	HOSPI CE	0	0	0	0.00		
11. 00	Other excluded areas	11, 692, 161	0	11, 692, 161			11. 00
12. 00	Subtotal Excluded salary (Sum of lines 7	12, 218, 339	0	12, 218, 339	572, 102. 86	21. 36	12. 00
40.00	through 11)	40 507 405		40 507 405	0/4 705 00		
13. 00	Total Adjusted Salaries (line 6 minus line	10, 527, 195	0	10, 527, 195	364, 735. 30	28. 86	13.00
	12)						
14. 00	OTHER WAGES & RELATED COSTS	255 251	1 0	355, 351	3, 916. 41	90, 73	14. 00
15. 00	Contract Labor: Patient Related & Mgmt	355, 351	0	355, 351	3, 916. 41		15. 00
16. 00	Contract Labor: Physician services-Part A Home office salaries & wage related costs	0	0	0	0.00		16. 00
16.00	WAGE-RELATED COSTS				0.00	0.00	16.00
17. 00	Wage-related costs core (See Part IV)	6, 446, 119		6, 446, 119			17. 00
18.00	Wage-related costs core (See Part IV)	134, 486		134, 486			18. 00
19. 00	Wage related costs other (see Part IV)	3, 521, 669		3, 521, 669			19. 00
20.00	Physician Part A - WRC	3, 321, 009		3, 521, 669			20. 00
21. 00	Physician Part B - WRC						21. 00
22. 00	Total Adjusted Wage Related cost (see	3, 058, 936		3, 058, 936			22. 00
22.00	instructions)	3,000,930	١	3,030,930			22.00
	This tructions)	1	I	I	I	1	

Nursing and Allied Health Ed. Act.

Other General Service

14.00 Total (sum lines 1 thru 13)

12.00

13.00

Provider No.: 315469

0

0

1, 055, 778

4, 770, 768

Peri od:

41, 171. 98

158, 723. 14

12.00

13.00

25. 64

30.06 14.00

Worksheet S-3 Part III Date/Time Prepared: From 01/01/2021 To 12/31/2021 9/7/2022 1:37 pm Average Hourly Amount Reclass. of Adj usted Paid Hours Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 5.00 1.00 2.00 3.00 4.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 149, 050 149, 050 3, 670. 12 40. 61 1.00 2.00 Administrative & General 51, 189. 82 2, 176, 430 0 2, 176, 430 42.52 2.00 20.77 3.00 Plant Operation, Maintenance & Repairs 1, 219, 792 0 1, 219, 792 58, 738. 16 3.00 4.00 Laundry & Linen Service 0.00 0.00 4.00 5.00 Housekeepi ng 0.00 0.00 5.00 0 42. 93 Di etary 169, 718 3, 953. 06 6.00 6.00 169, 718 0.00 Nursing Administration 7.00 0 0 0.00 7.00 8.00 Central Services and Supply 0 0 0 0.00 0.00 8.00 9.00 Pharmacy 0 0 0 0.00 0.00 9. 00 o Medical Records & Medical Records Library 0 0 0.00 10.00 0.00 10.00 Social Service 0 11.00 0 0 0.00 0.00 11.00

1, 055, 778

4, 770, 768

	10 12/31/202	1 Date/lime Prep 9/7/2022 1:37	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
Ī	Part A - Core List		
Ī	RETIREMENT COST		
1.00	401K Employer Contributions	491, 870	1. 00
	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4. 00
Ì	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	•	
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
Ī	HEALTH AND INSURANCE COST	•	
8.00	Health Insurance (Purchased or Self Funded)	3, 151, 233	8. 00
	Prescription Drug Plan	0	9. 00
	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	Workers' Compensation Insurance	988, 493	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
Ī	TAXES		
17. 00	FICA-Employers Portion Only	1, 723, 727	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	68, 361	20.00
	OTHER		
21. 00	Executive Deferred Compensation	0	21.00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	22, 435	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 - 23)	6, 446, 119	24.00
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS	134, 486	25. 00

Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES Provi der No.: 315469

					o 12/31/2021	Date/Time Prep 9/7/2022 1:37	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	Pili
	occupational outegoly	Reported		Salaries (col.		Wage (col. 3 ÷	
		opor tou	50011 00		Salary in col.	col. 4)	
					3		
		1.00	2. 00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	688, 977	0	688, 977	14, 231. 70	48. 41	1.00
2.00	Licensed Practical Nurses (LPNs)	1, 125, 000	0	1, 125, 000	29, 486. 86	38. 15	2.00
3.00	Certified Nursing Assistant/Nursing	1, 807, 705	0	1, 807, 705	77, 913. 29	23. 20	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 621, 682	0	3, 621, 682	121, 631. 85	29. 78	4. 00
5.00	Physical Therapists	108, 054	0	108, 054	2, 274. 58	47. 51	5. 00
6.00	Physical Therapy Assistants	88, 045	0	88, 045	2, 202. 05	39. 98	6.00
7.00	Physical Therapy Aides	0	0	C	0.00	0.00	7.00
8.00	Occupational Therapists	235, 790	0	235, 790	4, 831. 00	48. 81	8. 00
9.00	Occupational Therapy Assistants	0	0	C	0.00	0.00	9. 00
10.00	Occupational Therapy Aides	O	0	C	0.00	0.00	10.00
11.00	Speech Therapists	84, 282	0	84, 282	1, 773. 33	47. 53	11.00
12.00	Respi ratory Therapi sts	O	0	C	0.00	0.00	12.00
13.00	Other Medical Staff	O	0	C	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	141, 014		141, 014	1, 382. 38	102. 01	14.00
15.00	Licensed Practical Nurses (LPNs)	160, 231		160, 231	1, 549. 70	103. 39	15.00
16.00	Certified Nursing Assistant/Nursing	31, 907		31, 907	614. 33	51. 94	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	333, 152		333, 152	3, 546. 41	93. 94	
18.00	Physi cal Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		C	0.00	0.00	20.00
21.00	Occupational Therapists	0		C	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		C	0.00	0.00	22.00
23.00	Occupational Therapy Aides	o		C	0.00	0.00	23.00
24.00	Speech Therapists	o		C	0.00	0.00	24.00
25.00	Respi ratory Therapi sts	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	22, 200		22, 200	370.00	60.00	26.00

	Financial Systems CONT ASED HOME HEALTH AGENCY STATISTICAL DATA		Provi der	No.: 315469	Peri od:	Worksheet S-4	2540-
			HHA CCN:	317093	From 01/01/2021 To 12/31/2021	Date/Time Pre	
			Ti tl	e XVIII	Home Health Agency I	9/7/2022 1: 37 PPS	- рііі
		Title		Title XVIII	Title XIX	Other	
	HOME HEALTH ACENCY CTATICTICAL DATA	1.00)	2. 00	3. 00	4. 00	
00	HOME HEALTH AGENCY STATISTICAL DATA County	MONMOUTH					1. (
00	DESCRI PTI ON	INOMINOUTTI				1	'. \
00	Home Health Aide Hours		0	33	3O O	158	2. (
00	Unduplicated Census Count (see instructions)		0.00	141. C	0.00	67.00	3. (
				Staff	Contract	Total	
	WOME WENT TO ASSESS A SUBJECT OF		1.7	1.00	2. 00	3. 00	
00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FUL Enter the number of hours in your normal work		NI)	40.0	10		4.
00	Administrator and Assistant Administrator(s)	week		1. 2		1. 26	
00	Director(s) and Assistant Director(s)			0. 0			1
00	Other Administrative Personnel			1. 7			1
00	Direct Nursing Service			2. 2	0.00	2. 29	8.
00	Nursing Supervisor			O. C		1	
00	Physical Therapy Service			1. 0		l .	
00	Physical Therapy Supervisor			0.0		1	
00	Occupational Therapy Service Occupational Therapy Supervisor			0. 8 0. 0		l .	1
00				0. 0		1	
00	Speech Pathology Supervisor			0. 0			1
00	Medical Social Service			O. C	0.00	0.00	16.
00	Medical Social Service Supervisor			O. C			
00				0. 2		1	1
00	Home Heal th Ai de Supervi sor			0. 0		l .	
00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	20.
00	Enter in column 1 the number of CBSAs where	you provided ser	vices during		3		21.
00	` /	during this cos	t reporting	35154			22.
01	period (line 22 contains the first code). List those CBSA code(s) in column 1 serviced	during this cos	t reporting	50012			22.
02	period (line 22 contains the first code). List those CBSA code(s) in column 1 serviced	during this cos	t reporting	50020			
02				50020			
02	List those CBSA code(s) in column 1 serviced	Full Epi	t reporting sodes With Outliers		s PEP Only	Total (columns	22
02	List those CBSA code(s) in column 1 serviced	Full Epi Without W Outliers	sodes //ith Outliers	LUPA Epi sode:	Epi sodes	1 through 4)	22.
02	List those CBSA code(s) in column 1 serviced period (line 22 contains the first code).	Full Epi Without W	sodes				22.
	List those CBSA code(s) in column 1 serviced period (line 22 contains the first code). PPS ACTIVITY DATA	Full Epi Without W Outliers 1.00	sodes Vith Outliers 2.00	LUPA Epi sode:	Epi sodes 4.00	1 through 4) 5.00	22.
00	List those CBSA code(s) in column 1 serviced period (line 22 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits	Full Epi Without W Outliers 1.00	sodes With Outliers 2.00	LUPA Epi sode:	Epi sodes 4. 00	1 through 4) 5.00	22.
00 00	List those CBSA code(s) in column 1 serviced period (line 22 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges	Full Epi Without Outliers 1.00 645 112,875	sodes /i th Outliers 2.00 113 19,775	3. 00 3. 70	Epi sodes 4. 00	1 through 4) 5.00 791 138, 425	22. 23. 24.
00 00 00	List those CBSA code(s) in column 1 serviced period (line 22 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges	Full Epi Without W Outliers 1.00	sodes With Outliers 2.00	3. 00 3. 70	Epi sodes 4. 00	1 through 4) 5.00 791 138, 425 643	23. 24. 25.
00 00 00 00	List those CBSA code(s) in column 1 serviced period (line 22 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges	Full Epi Without Outliers 1.00 645 112,875 546	sodes /ith Outliers 2.00 113 19,775 83	3. 00 3. 00 3. 77 1 2, 80	Epi sodes 4. 00	1 through 4) 5.00 791 138, 425 643 128, 600	22 23 24 25 26
00 00 00 00 00 00	List those CBSA code(s) in column 1 serviced period (line 22 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges	Full Epi Without Outliers 1.00 645 112,875 546 109,200 382 76,400	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800	3. 00 3. 00 3. 77 1 2, 80	Epi sodes 4.00 33 05 04 00 07	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600	23 24 25 26 27 28
00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15	3.00 3.00 3.77 1 2,80	Epi sodes 4. 00 (15) 00 00 00 00 00 00 00 00 00 0	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75	23 24 25 26 27 28 29
00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit S Speech Pathology Visit Charges	Full Epi Without Outliers 1.00 645 112,875 546 109,200 382 76,400	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000	3.00 3.00 3.77 1 2,80	Epi sodes 4. 00 33	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000	23 24 25 26 27 28 29 30
00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit S Speech Pathology Visit Charges Medical Social Service Visits	Full Epi Without Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2	sodes /i th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0	3.00 3.00 3.77 1 2,80	Epi sodes 4.00 33 00 4 00 07 00 00 00 00 00 00 00 00 00 00 00	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2	23 24 25 26 27 28 29 30 31
00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400	sodes /i th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0	3.00 3.00 3.77 1 2,80	Epi sodes 4. 00 33	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15,000 2 400	23 24 25 26 27 28 29 30 31 32
00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges	Full Epi Without Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2	sodes /i th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0	3.00 3.00 3.77 1 2,80	Epi sodes 4.00 (3) (4) (5) (5) (6) (7) (6) (7) (7) (7) (8) (9) (9) (9) (9) (9) (1) (1) (1) (2) (1) (1) (2) (1) (2) (1) (2) (1) (2) (2) (3) (4) (6) (7) (7) (7) (8) (9) (9) (9) (9) (9) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2	23 24 25 26 27 28 29 30 31 32 33
00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges	Full Epi Without Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114	sodes /i th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55	3. 00 3. 00 3. 77 1 2, 80 1, 40	Epi sodes 4.00 (3) (4) (5) (5) (6) (7) (6) (7) (7) (7) (8) (9) (9) (9) (9) (9) (1) (1) (1) (2) (1) (1) (2) (1) (2) (1) (2) (1) (2) (2) (3) (4) (6) (7) (7) (7) (8) (9) (9) (9) (9) (9) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	1 through 4) 5.00 791 138,425 643 128,600 493 98,600 75 15,000 2 400 170	23 24 25 26 27 28 29 30 31 32 33 34
00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Total Visits (sum of lines 23, 25, 27, 29, 31, and 33)	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55 6,875	3. 00 3. 00 3. 77 1 2, 80 1, 40	Epi sodes 4. 00 23 05 4 00 00 00 00 00 00 01 10 10	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2 400 170 21, 250 2, 174	23 24 25 26 27 28 29 30 31 32 33 34 35
00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Home Health Aide Visit Charges Total Visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 0 0 55 6,875 370 0	3.00 3.00 3.77 12,80 1,40	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2 400 170 21, 250 2, 174	23 24 25 26 27 28 30 31 32 33 34 35
00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visits Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges Total Charges (sum of lines 24, 26, 28, 30,	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55 6,875	3. 00 3. 00 3. 77 1 2, 80 1, 40	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2 400 170 21, 250 2, 174	23 24 25 26 27 28 29 30 31 32 33 34 35
00 00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges Total Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36) Total Number of Episodes (standard/non	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 0 0 55 6,875 370 0	3. 00 3. 00 5, 77 1 2, 80 1, 40	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2 400 170 21, 250 2, 174 0 402, 275	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
00 00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36) Total Number of Episodes (standard/non outlier)	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749 0 325,125	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 0 0 55 6,875 370 0	3. 00 3. 00 5, 77 1 2, 80 1, 40	Epi sodes 4.00 33 00 44 00 7 00 00 00 00 01 11 00 125 00 00 00 00 00 00 00 00 00	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 170 21, 250 2, 174 0 402, 275	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
00 00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges Total Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36) Total Number of Episodes (standard/non outlier)	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749 0 325,125 195	sodes ith Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55 6,875 370 0 67,050	3. 00 3. 00 5, 77 1 2, 80 1, 40	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2400 170 21, 250 2, 174 0402, 275 229	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
00 00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges Total Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36) Total Number of Episodes (standard/non outlier) Total Number of Outlier Episodes	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749 0 325,125 195 5,760 Total	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55 6,875 370 0 67,050	12, 80 10, 10	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2400 170 21, 250 2, 174 0402, 275 229	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
00 00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Home Health Aide Visit Charges Total Visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges Total Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36) Total Number of Episodes (standard/non outlier) Total Number of Outlier Episodes Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749 0 325,125 195	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55 6,875 370 0 67,050	12, 80 10, 10	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2400 170 21, 250 2, 174 0402, 275 229	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
00 00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges Total Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36) Total Number of Episodes (standard/non outlier) Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749 0 325,125 195 5,760 Total	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55 6,875 370 0 67,050	12, 80 10, 10	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2400 170 21, 250 2, 174 0402, 275 229	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
00 00 00 00 00 00 00 00 00 00 00 00 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 23, 25, 27, 29, 31, and 33) Other Charges Total Charges (sum of lines 24, 26, 28, 30, 32, 34, and 36) Total Number of Episodes (standard/non outlier) Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	Full Epi Wi thout Outliers 1.00 645 112,875 546 109,200 382 76,400 60 12,000 2 400 114 14,250 1,749 0 325,125 195 5,760 Total	sodes // th Outliers 2.00 113 19,775 83 16,600 104 20,800 15 3,000 0 0 55 6,875 370 0 67,050	12, 80 10, 10	Epi sodes 4. 00 13	1 through 4) 5.00 791 138, 425 643 128, 600 493 98, 600 75 15, 000 2400 170 21, 250 2, 174 0402, 275 229	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der No.: 315469	Peri od:	Worksheet S-	7
		From 01/01/2021 To 12/31/2021	Date/Time Pro	epared:
		Group	9/7/2022 1: 3 Days	/ pm
100		1. 00	2. 00	1.00
1. 00 2. 00		RUX RUL		1. 00 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 13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16.00
17. 00 18. 00		RHB RHA		17. 00 18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21. 00		RMA		21.00
22. 00 23. 00		RLB RLA		22. 00 23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00 28. 00		HE2 HE1		27. 00 28. 00
29. 00		HD2		29. 00
30. 00		HD1		30.00
31. 00		HC2		31. 00
32. 00 33. 00		HC1 HB2		32. 00 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 43. 00		LB1 CE2		42. 00 43. 00
44.00		CE1		44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00 48. 00		CC2 CC1		47. 00 48. 00
49. 00		CB2		49. 00
50. 00		CB1		50. 00
51. 00		CA2		51.00
52. 00 53. 00		CA1 SE3		52. 00 53. 00
54. 00		SE2		54. 00
55. 00		SE1		55. 00
56.00		SSC		56.00
57. 00 58. 00		SSB SSA		57. 00 58. 00
59. 00		1 B2		59. 00
60. 00		I B1		60.00
61.00		I A2		61.00
62. 00 63. 00		I A1 BB2		62. 00 63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66.00
67. 00 68. 00		PE2 PE1		67. 00 68. 00
69. 00		PD2		69.00
70. 00		PD1		70. 00
71. 00		PC2		71. 00
72.00		PC1		72.00
73. 00 74. 00		PB2 PB1		73. 00 74. 00
75. 00		PA2		75. 00
		1	•	

Health Financial Systems CONTINUING CARE	AT SEABROOK VILLA	AGE	In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Peri od:	Worksheet S-	7
			From 01/01/2021 To 12/31/2021	Date/Time Pr 9/7/2022 1:3	
			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 payments beginning 10/01/2003. Congress expected this in expenses. For lines 101 through 106: Enter in column 1 the column 2 the percentage of total expenses for each categoriem 1, column 3. Indicate in column 3 "Y" for yes or "N with direct patient care and related expenses for each categoriem (See instructions)	crease to be used he amount of the ory to total SNF " for no if the s	I for direct p expense for e revenue from spending refle	atient care and ach category. Er Worksheet G-2, F cts increases as	related hter 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

	Financial Systems CONT SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	INUING CARE AT SI EXPENSES		No.: 315469 F	Peri od:	wof Form CMS-2 Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	nared·
						9/7/2022 1: 37	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance	
				+ (01. 2)	Increase/Decre		
					ase (Fr Wkst	col . 4)	
					A-6)		
	CENEDAL CEDALCE COST CENTEDS	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FLXTURES		19, 744, 012	19, 744, 012	0	19, 744, 012	1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 176, 525			1, 176, 525	2.00
3. 00	00300 EMPLOYEE BENEFITS	149, 050	6, 580, 605			6, 729, 655	3.00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 176, 430	4, 542, 851	6, 719, 281			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 219, 792	982, 015	2, 201, 807	0	2, 201, 807	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	0	(0	0	6. 00
7.00	00700 HOUSEKEEPI NG	0	127 452	207.170	0	0	7.00
8. 00 9. 00	OO8OO DI ETARY OO9OO NURSI NG ADMI NI STRATI ON	169, 718	137, 452	307, 170	0	307, 170 0	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY		0			0	10.00
	01100 PHARMACY		0			0	11.00
	01200 MEDICAL RECORDS & LIBRARY	o	0	d	o o	0	12. 00
13.00	01300 SOCIAL SERVICE	0	0	(0	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	0	14.00
15. 00	01500 ACTI VI TI ES	1, 055, 778	-10, 664	1, 045, 114	1 0	1, 045, 114	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 240 257	2 121 772	7 2/1 02/	24 502	7 200 522	20.00
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	5, 240, 257	2, 121, 673	7, 361, 930	26, 593	7, 388, 523 0	30.00
	03200 CF/IID		0			0	32.00
	03300 OTHER LONG TERM CARE		0			Ö	33.00
	ANCILLARY SERVICE COST CENTERS	-1					
40.00	04000 RADI OLOGY	0	28, 931	28, 931	0	28, 931	40. 00
	04100 LABORATORY	0	11, 453			11, 453	
42. 00	04200 NTRAVENOUS THERAPY	0	26, 169			26, 169	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	8, 883			8, 883	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 0CCUPATI ONAL THERAPY	196, 099 235, 789	10, 683 277	206, 782 236, 066		206, 782 236, 066	
	04500 SPEECH PATHOLOGY	84, 282	704			84, 986	
	04700 ELECTROCARDI OLOGY	04, 202	0	04, 700		04, 700	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125, 640	125, 640	0	125, 640	
	04900 DRUGS CHARGED TO PATIENTS	0	158, 951	158, 951	0	158, 951	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(1	0	50.00
	05100 SUPPORT SURFACES	0	153	153		153	
52. 00	05200 OTHER ANCILLARY SERVICE OUTPATIENT SERVICE COST CENTERS	0	0) 0	0	52.00
60.00	06000 CLINIC		0		0	0	60.00
	06100 RURAL HEALTH CLINIC		0			Ö	
62. 00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	526, 178	110, 401	636, 579	0	636, 579	
	07100 AMBULANCE	0	0	(0	0	71.00
	07200 CORF 07210 OPT	382, 067	49, 082	431, 149		0 431, 149	72. 00 72. 10
	07300 CMHC	302,007	49, 002 0	431, 143	0	431, 149	1
	07400 OTHER REIMBURSABLE COST		0		o o	ő	
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	(0	0	80.00
	08100 I NTEREST EXPENSE		0		0	0	81.00
	08200 UTI LI ZATI ON REVI EW	0	0		0	0	
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0		0	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	11, 435, 440	35, 805, 796	47, 241, 236	-78, 960	47, 162, 276	1
57.00	NONREI MBURSABLE COST CENTERS	, 100, 440	55, 555, 776	1 .,, 2 + 1, 230	., ,0,,,00	.,, 102, 270	1 27.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	(0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	
	09300 NONPAI D WORKERS	0	0	(0	0	93.00
	09400 PATIENTS LAUNDRY	10 433 400	10 242 242	20 (0) 25	0 70 000	0	94.00
	09500 OTHER NONREI MBURSABLE COST 09501 MARKETI NG	10, 432, 409 877, 685	10, 263, 943 2, 114, 002			20, 775, 312 2, 991, 687	1
100.00		22, 745, 534	48, 183, 741				
100.00	TUTAL	22, 745, 534	48, 183, /41	70, 929, 275	0	70, 929, 275	1100.

Health Financial Systems CONTINUING CARE AT SEABROOK VILLAGE In Lieu of Form CMS-2540-10 RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provider No.: 315469 Peri od: Worksheet A From 01/01/2021 12/31/2021 Date/Time Prepared: 9/7/2022 1:37 pm Cost Center Description Adjustments to Net Expenses Expenses (Fr For Allocation (col. 5 +-col. 6) Wkst A-8) 6.00 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 19, 497, 802 -246, 210 1, 176, 525 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFLTS 3.00 -42 001 6, 687, 654 4.00 00400 ADMINISTRATIVE & GENERAL -2, 789, 187 3, 824, 541 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 2, 201, 807 00600 LAUNDRY & LINEN SERVICE 6.00 0 7.00 00700 HOUSEKEEPI NG 191, 152 8.00 00800 DI ETARY -116, 018 9.00 00900 NURSING ADMINISTRATION 0 01000 CENTRAL SERVICES & SUPPLY 0 10.00 0 11.00 01100 PHARMACY 0 0 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 01300 SOCIAL SERVICE 0 0 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 15.00 01500 ACTI VI TI ES -26, 512 1,018,602 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 -304, 670 03000 SKILLED NURSING FACILLTY 7 083 853 31.00 03100 NURSING FACILITY 32.00 03200 | CF/IID 0 0 33.00 03300 OTHER LONG TERM CARE 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 28, 931 0 41.00 04100 LABORATORY 11, 453 42 00 04200 I NTRAVENOUS THERAPY 26, 169

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 30.00 31.00 32.00 33.00 40.00 41.00 0 0 42 00 43.00 04300 OXYGEN (INHALATION) THERAPY 8,883 43.00 44.00 04400 PHYSI CAL THERAPY 206, 782 44.00 04500 OCCUPATIONAL THERAPY 45.00 00000 236, 066 45.00 04600 SPEECH PATHOLOGY 46 00 46 00 84, 986 47.00 04700 ELECTROCARDI OLOGY 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 125, 640 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 158, 951 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 50.00 Ω 51.00 05100 SUPPORT SURFACES 0 153 51.00 05200 OTHER ANCILLARY SERVICE 52.00 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 0 60.00 06000 CLI NI C 0 61.00 06100 RURAL HEALTH CLINIC 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 63.00 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST -38, 867 597, 712 70.00 71.00 07100 AMBULANCE 71.00 07200 CORF 72.00 0 72.00 72.10 07210 OPT 10, 932 442, 081 72.10 73.00 07300 CMHC 73.00 07400 OTHER REIMBURSABLE COST 74.00 74.00 0 0 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 0 81.00 0 81.00 08200 UTILIZATION REVIEW 82.00 0 0 82.00 83.00 08300 H0SPI CE 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 84.00 SUBTOTALS (sum of lines 1-84) -3, 552, 533 43, 609, 743 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 09100 BARBER AND BEAUTY SHOP 91.00 0 0 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 92.00 0 09300 NONPALD WORKERS 0 93.00 0 93.00 94. 00 | 09400 | PATI ENTS LAUNDRY 0 94.00 09500 OTHER NONREIMBURSABLE COST 95.00 -179, 467 20, 595, 845 95.00 95. 01 09501 MARKETI NG -30462, 988, 641 95 01 100.00 TOTAL -3, 735, 046 67, 194, 229 100.00

Health Financial Systems			CONTINUING CARE AT SEABROOK VILLAGE			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS				Provi der		Peri od: From 01/01/2021 To 12/31/2021	Worksheet A-6 Date/Time Pre		
						10 12/31/2021	9/7/2022 1: 37		
			Increases						
			Cost Cente	r	Li ne #	Sal ary	Non Salary		
			2. 00		3. 00	4. 00	5. 00		
	(1) A - MEDICAL DIRECTOR RECLASS								
1.00			SKILLED NURSING FAC	CLLITY	30.0	00	26, 593	1. 00	
2.00			OTHER NONRELMBURSAE	BLE COST	95. 0	00	78, 960	2.00	
	TOTALS								
100.00			Total Reclassificat	tions (Sum		0	105, 553	100. 00	
			of columns 4 and 5 equal sum of column						
			9)	is o and					

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

Health Financial Systems		CONTINUING CARE AT SEABROOK VILLAGE			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provi d	er No.: 315469		ri od:	Worksheet A-6		
				To	om 01/01/2021 12/31/2021	Date/Time Prep 9/7/2022 1:37	pared:	
			Decreases					
		Cost Center	Li ne #		Sal ary	Non Salary		
		6. 00	7. 00		8. 00	9. 00		
(1) A - MEDICAL DIRECTOR RECLASS								
1.00		ADMINISTRATIVE & GENERAL	4.	00	0	105, 553	1.00	
2.00			0.	00	0	0	2.00	
TOTALS								
100. 00					0	105, 553	100. 00	

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der No.: 315469

						9/7/2022 1: 37	pm
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	16, 749, 004	0	0	0	0	1.00
2.00	Land Improvements	3, 171, 315	94, 393	0	94, 393	0	2.00
3.00	Buildings and Fixtures	297, 084, 283	12, 254, 257	0	12, 254, 257	0	3.00
4.00	Building Improvements	46, 216	0	0	0	29, 710	4.00
5.00	Fixed Equipment	1, 538, 510	0	0	0	212, 015	5.00
6.00	Movable Equipment	7, 168, 715	0	0	0	1, 198, 975	6.00
7.00	Subtotal (sum of lines 1-6)	325, 758, 043	12, 348, 650	0	12, 348, 650	1, 440, 700	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	325, 758, 043	12, 348, 650	0	12, 348, 650	1, 440, 700	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	16, 749, 004	0				1.00
2.00	Land Improvements	3, 265, 708	0				2.00
3.00	Buildings and Fixtures	309, 338, 540	0				3.00
4.00	Building Improvements	16, 506	0				4.00
5.00	Fi xed Equipment	1, 326, 495	0				5.00
6.00	Movable Equipment	5, 969, 740	0				6.00
7.00	Subtotal (sum of lines 1-6)	336, 665, 993	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	336, 665, 993	0				9.00
		·					

ADJUSTMENTS TO EXPENSES

Provider No.: 315469

Peri od: From 01/01/2021 To 12/31/2021

Worksheet A-8
Date/Time Prepared:

9/7/2022 1:37 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Description (1) (2) Basis For Cost Center Li ne No. Amount Adjustment 2.00 3.00 4.00 1.00 1 00 0.00 1 00 Investment income on restricted funds (chapter 2) 2.00 Trade, quantity, and time discounts (chapter 0 0.00 2.00 3.00 Refunds and rebates of expenses (chapter 8) 0.00 3.00 0 00 4.00 Rental of provider space by suppliers Ω 4 00 (chapter 8) 5.00 Telephone services (pay stations excluded) 0 00 5.00 (chapter 21) Television and radio service (chapter 21) 6.00 0.00 6.00 0.00 7.00 7.00 Parking lot (chapter 21) 8.00 Remuneration applicable to provider-based A-8-2 8.00 physician adjustment 9.00 Home office cost (chapter 21) 0.00 9.00 10.00 Sale of scrap, waste, etc. (chapter 23) 0.00 10.00 Nonallowable costs related to certain 0.00 11.00 11.00 Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with A-8-1 -3, 015, 869 12.00 related organizations (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14 00 Ω 0.00 14 00 Revenue - Employee meals Cost of meals - Guests 15.00 C 0.00 15.00 16.00 Sale of medical supplies to other than 0.00 16.00 pati ents 17 00 Sale of drugs to other than patients 0.00 17.00 -471 ADMINI STRATI VE & GENERAL 4.00 Sale of medical records and abstracts 18.00 В 18.00 19.00 Vending machines B -1,823 OTHER NONREIMBURSABLE COST 95.00 19.00 Income from imposition of interest, finance 20.00 0.00 20.00 or penalty charges (chapter 21) 0.00 21.00 21 00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments Utilization review--physicians' compensation OUTILIZATION REVIEW 82.00 22.00 22.00 (chapter 21) 23.00 Depreciation--buildings and fixtures OCAP REL COSTS - BLDGS & 1.00 23.00 FLXTURES. Depreciation--movable equipment OCAP REL COSTS - MOVABLE 2.00 24.00 24.00 EQUI PMENT 25.00 CONTRI BUTI ONS -1,198ADMINISTRATIVE & GENERAL 4.00 25.00 25. 01 GIFT SHOP REVENUE В -124, 139 OTHER NONREI MBURSABLE COST 95.00 25.01 -35, 510 OTHER NONREI MBURSABLE COST GUEST ROOM RENT REVENUE 95.00 25.02 25.02 В 25.03 ENTERTAI NMENT Α -13, 620 DI ETARY 8.00 25.03 25. 04 ENTERTAL NMENT Α -366 ADMINISTRATIVE & GENERAL 4.00 25.04 ADVERTISING AND PR EXPENSE -972 MARKETI NG 95.01 25.05 Α 25.05 -135 MARKETI NG ADVERTISING AND PR EXPENSE 95 01 25.06 Α 25.06 25.07 LI QUOR 40 SKILLED NURSING FACILITY 30.00 25.07 4, 930 OTHER NONREI MBURSABLE COST 25.08 LI OUOR Α 95.00 25.08 -2. 759 OTHER NONREI MBURSABLE COST 95.00 25.09 LI QUOR 25.09 Α 25.10 ADVERTISING AND PR EXPENSE Α -56 MARKETI NG 95.01 25.10 25. 11 ADVERTISING AND PR EXPENSE Α -5,525 OTHER NONREIMBURSABLE COST 95.00 25.11 25. 12 INTERNET ADVERTISING -430 DI ETARY 8.00 25.12 Α LEASE REVENUE В -19, 523 OTHER NONREI MBURSABLE COST 95.00 25 14 25 14 25.15 BAD DEBT Α -13, 232 SKILLED NURSING FACILITY 30.00 25, 15 LI QUOR 145 OTHER NONREIMBURSABLE COST 95.00 25. 16 25. 16 25. 17 BAD DEBT -78,502 SKILLED NURSING FACILITY 30.00 25.17 Α BAD DEBT -15, 243 HOME HEALTH AGENCY COST 70 00 25 18 25 18 Α 25. 19 LEASE REVENUE В -74, 224 OTHER NONREI MBURSABLE COST 95.00 25.19 ADVERTISING AND PR EXPENSE -1, 883 MARKETI NG 95.01 25. 20 Α 25.20 25, 21 ADVERTISING AND PR EXPENSE Α -29 EMPLOYEE BENEFITS 3.00 25, 21 -513 OTHER NONREI MBURSABLE COST 95.00 25. 22 GI FTS Α 25. 22 25. 23 BAD DEBT -87, 929 ADMINISTRATIVE & GENERAL 4.00 25. 23 Α INTEREST INCOME --246, 210 CAP REL COSTS - BLDGS & 25. 24 1.00 25. 24 FI XTURES 100.00 100.00 Total (sum of lines 1 through 99) (Transfer -3, 735, 046 to Worksheet A, col. 6, line 100)

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

Health Financial Systems CONTINUING CARE AT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME In Lieu of Form CMS-2540-10 CONTINUING CARE AT SEABROOK VILLAGE Peri od: Worksheet A-8-1
From 01/01/2021 Parts I-II
To 12/31/2021 Date/Time Prepared: 9/7/2022 1: 37 pm

Expense I tems Provi der No.: 315469 OFFICE COSTS Line No. Cost Cantar

		Line No.	Cost (Center	Expense Items	
		1. 00	2.	00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
	CLAIMED HOME OFFICE COSTS:					
1.00			EMPLOYEE BENEF		HOME OFFICE COSTS	1.00
2.00			ADMI NI STRATI VE	& GENERAL	HOME OFFICE COSTS	2.00
3.00			DI ETARY		HOME OFFICE COSTS	3.00
4.00			ACTI VI TI ES		HOME OFFICE COSTS	4.00
5.00					HOME OFFICE COSTS	5.00
6.00			HOME HEALTH AG	ENCY COST	HOME OFFICE COSTS	6.00
7.00		72. 10	1		HOME OFFICE COSTS	7.00
8.00			OTHER NONREIMB	URSABLE COST	HOME OFFICE COSTS	8. 00
9.00		0. 00				9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column					10. 00
	6, line 100 to Worksheet A-8, column 3, line					
	12.					4
		Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col . 5)		
		4. 00	5. 00	6, 00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR				D ODCANI ZATLONS OD	_
	CLAIMED HOME OFFICE COSTS:	KLD AS A KLSULI	UI TRANSACTIO	NS WITH KLLAIL	D ORGANIZATIONS OR	
1.00	CEATIMED HOME OFFICE COSTS.	0	41, 972	-41, 972		1.00
2.00		0	2, 699, 223			2.00
3.00		0	101, 968			3. 00
4. 00		0	26, 512			4.00
5. 00		519, 386				5. 00
6.00		36, 491	60, 115			6.00
7. 00		25, 502				7. 00
8.00		2, 883, 653				8.00
9. 00		0	0	0		9. 00
10.00	TOTALS (sum of lines 1-9). Transfer column	3, 465, 032	6, 480, 901	-3, 015, 869		10.00
	6, line 100 to Worksheet A-8, column 3, line					
	12					1

ical til Tillaneral Systems	THOTHE OTHE THE	SEMBROOK VI LENGE	THI LI C	u 01 101111 01110 2	_0 10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZA DFFICE COSTS	ATIONS AND HOME		Period: From 01/01/2021 To 12/31/2021	Worksheet A-8- Parts I-II Date/Time Prep 9/7/2022 1:37	pared:
	Symbol (1)	Name	Percentage of		

2.00

Ownershi p

3.00

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.

1.00

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

1.00		В	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 Ownership	Type of Business
DART LL LATERDEL ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6.00

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. 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		ERICKSON LIVING MANAGEMENT	0.00	CCRC MGMT/DVPM	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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Provider No.: 315469

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 9/7/2022 1:37 pm CAPITAL RELATED COSTS Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal Cost Center Description for Cost **FLXTURES FOUL PMENT** BENEFITS Allocation (from Wkst A col. 7) 1.00 2.00 3. 00 3A GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 19, 497, 802 1 00 19, 497, 802 1 00 2.00 1, 176, 525 1, 176, 525 2 00 3.00 00300 EMPLOYEE BENEFITS 6, 687, 654 6, 687, 654 3.00 00400 ADMINISTRATIVE & GENERAL 4 00 3 824 541 O 4 468 677 4 00 644, 136 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 2, 201, 807 0 361, 010 2, 562, 817 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 0 6.00 7.00 00700 HOUSEKEEPI NG 0 7.00 0 00800 DI FTARY 191, 152 50, 230 241, 382 8 00 8 00 9.00 00900 NURSING ADMINISTRATION Ω 9.00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 0 0 10.00 01100 PHARMACY 0 11.00 0 11.00 0 01200 MEDICAL RECORDS & LIBRARY 12.00 0 0 0 12.00 13.00 01300 SOCIAL SERVICE 0 0 0 13.00 0 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 14.00 01500 ACTI VI TI ES 1,018,602 0 1, 331, 070 15.00 312, 468 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 7, 083, 853 780, 932 1, 550, 906 9, 462, 814 30.00 30.00 47, 123 31.00 03100 NURSING FACILITY 0 31.00 0 32.00 03200 LCF/LLD 0 0 32.00 0 0 0 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 28, 931 C 28, 931 40.00 04100 LABORATORY 0 0 0 11, 453 41.00 11.453 41.00 04200 I NTRAVENOUS THERAPY 42.00 26, 169 0 0 0 26, 169 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 8,883 8,883 43.00 44.00 04400 PHYSI CAL THERAPY 206, 782 0 58, 037 264, 819 44.00 04500 OCCUPATIONAL THERAPY 45.00 236, 066 0 69, 784 305, 850 45 00 04600 SPEECH PATHOLOGY 24, 944 46.00 84, 986 109, 930 46,00 47.00 04700 ELECTROCARDI OLOGY 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 125, 640 0 125, 640 48 00 0 48 00 49.00 04900 DRUGS CHARGED TO PATIENTS 158, 951 0 0 158, 951 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 o 50.00 0 50.00 05100 SUPPORT SURFACES 0 0 51.00 153 51.00 153 05200 OTHER ANCILLARY SERVICE O 52.00 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C C 0 60.00 61 00 06100 RURAL HEALTH CLINIC 0 ol 0 C 0 61 00 62.00 06200 FQHC 62.00 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 70 00 07000 HOME HEALTH AGENCY COST 597, 712 12, 495 754 766, 689 155, 728 71.00 07100 AMBULANCE C 0 71.00 72.00 07200 CORF 72.00 0 0 72.10 07210 OPT 442,081 14, 942 902 113,077 571,002 72.10 07300 CMHC 73 00 0 0 73 00 74.00 07400 OTHER REIMBURSABLE COST 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 H0SPI CE 0 83 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 84 00 0 0 84 00 89.00 SUBTOTALS (sum of lines 1-84) 43, 609, 743 808, 369 48, 779 3, 340, 320 20, 445, 230 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 C 0 0 09100 BARBER AND BEAUTY SHOP 0 0 91.00 C 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 92.00 09300 NONPALD WORKERS 93 00 93.00 09400 PATIENTS LAUNDRY 94.00 94.00 0 3, 087, 574 20, 595, 845 43, 500, 598 95.00 09500 OTHER NONREI MBURSABLE COST 18, 689, 433 1, 127, 746 95 00 3, 248, 401 09501 MARKETI NG 2, 988, 641 259, 760 95.01 95.01 98.00 Cross Foot Adjustments 0 0 98.00 99.00 Negative Cost Centers 0 99.00 100.00 TOTAL 67, 194, 229 19, 497, 802 1, 176, 525 6, 687, 654 67, 194, 229 100. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315469 Period:

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

9/7/2022 1: 37 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 4, 468, 677 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 182, 580 2, 745, 397 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 0 7 00 8.00 00800 DI ETARY 17.197 0 0 258, 579 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 0 01000 CENTRAL SERVICES & SUPPLY 0 0 10.00 Ω Ω 10.00 0 11.00 01100 PHARMACY 0 0 0 11.00 0 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 01300 SOCIAL SERVICE 0 0 13.00 13.00 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00 Ω 0 14.00 15.00 01500 ACTI VI TI ES 94,828 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 25, 217 30.00 674, 150 109 960 O 0 0 31.00 03100 NURSING FACILITY 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 2,061 0 0 0 0 40.00 41.00 04100 LABORATORY 816 0 0 0 0 0 0 0 41.00 0 42 00 04200 I NTRAVENOUS THERAPY Ω 0 42 00 1,864 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 633 0 0 43.00 04400 PHYSI CAL THERAPY 18, 866 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 21, 789 0 0 45.00 04600 SPEECH PATHOLOGY 46 00 0 46 00 7.832 0 04700 ELECTROCARDI OLOGY 0 47.00 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 951 0 0 48.00 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 11, 324 0 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 Ω 50.00 0 0 51.00 05100 SUPPORT SURFACES 11 C 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE 52.00 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 Ω 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 63.00 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 54,620 1, 759 C 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 71.00 07200 CORF 0 72.00 0 C 0 72.00 0 72.10 07210 OPT 40, 679 2, 104 0 0 72.10 73.00 07300 CMHC 0 0 73.00 07400 OTHER REIMBURSABLE COST 74.00 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 83.00 08300 H0SPI CE 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 84.00 SUBTOTALS (sum of lines 1-84) 1, 138, 201 113, 823 25, 217 89.00 89.00 0 0 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 91.00 0 0 0 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 92.00 0 0 09300 NONPALD WORKERS 0 93.00 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00 09500 OTHER NONREIMBURSABLE COST 95.00 3, 099, 053 2, 631, 574 0 0 233, 362 95.00 95 01 09501 MARKETI NG 231, 423 0 95 01 0 0 98.00 Cross Foot Adjustments C 0 98.00 99.00 Negative Cost Centers 0 0 99.00 0 100.00 TOTAL 4, 468, 677 2, 745, 397 258, 579 100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315469

						9/7/2022 1: 37	pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		9. 00	10.00	11.00	12. 00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6.00
7. 00 8. 00	00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00	01000 CENTRAL SERVICES & SUPPLY		0				10.00
11. 00	01100 PHARMACY	0	0	0			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	o	0	ol ol	0		12. 00
13. 00	01300 SOCIAL SERVICE	0	0	O	0	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	o	0	0	14. 00
15. 00	01500 ACTI VI TI ES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	0		0	-	30. 00
31. 00	03100 NURSING FACILITY	0	0	1	0	-	31.00
32.00	03200 CF/IID	0	0	0	0		32.00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	33. 00
40. 00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY		0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0		0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	Ö	0	l o	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	O	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	O	0	О	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	52.00
60. 00	06000 CLINIC	O	0	o	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	06200 FQHC		0		0	Ĭ	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	o	0	o	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0	0	0	0	71. 00
72. 00	07200 CORF	0	0	0	0	0	72. 00
72. 10	07210 OPT	0	0	0	0	0	72. 10
73.00	07300 CMHC	0	0	0	0	0	73.00
74. 00	07400 OTHER REIMBURSABLE COST	<u> </u>	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			I		I	80.00
81. 00	08100 INTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	o	0		0		
89. 00	SUBTOTALS (sum of lines 1-84)	0	0	О	0	0	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0		90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		0	_	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	1
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
95. 00 95. 01	09500 OTHER NONREI MBURSABLE COST	0	0	0	0	0	1
95. 01 98. 00	09501 MARKETING Cross Foot Adjustments	0	0	0	Ü		95. 01 98. 00
99. 00	Negative Cost Centers	0	0	o	0	0	
100.00		o	0		0		100.00
	•						•

Provider No.: 315469

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

Part I

From 01/01/2021 Date/Time Prepared: 12/31/2021 9/7/2022 1:37 pm OTHER GENERAL SERVI CE NURSI NG AND ACTI VI TI ES Post Stepdown Total Cost Center Description Subtotal ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 01100 PHARMACY 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 ACTI VI TI ES 15.00 0 1, 425, 898 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 57, 082 10, 329, 223 0 10, 329, 223 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 0 32.00 0 03200 | CF/IID 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 O 0 33 00 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 30, 992 30, 992 40.00 41.00 04100 LABORATORY 0000000000 0 12, 269 0 12, 269 41.00 04200 I NTRAVENOUS THERAPY 42 00 42 00 Ω 28.033 28.033 43.00 04300 OXYGEN (INHALATION) THERAPY 9, 516 9, 516 43.00 04400 PHYSI CAL THERAPY 283, 685 283, 685 44.00 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 327, 639 327, 639 45.00 04600 SPEECH PATHOLOGY 46.00 C 117, 762 117, 762 46.00 0 47.00 04700 ELECTROCARDI OLOGY 47.00 0 134, 591 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 134, 591 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 0 49.00 170, 275 170, 275 05000 DENTAL CARE - TITLE XIX ONLY 0 50 00 C Γ Λ 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 164 164 52.00 05200 OTHER ANCILLARY SERVICE 0 0 0 ol 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 n O 0 Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 63.00 0 0 0 Λ 63.00 OTHER REIMBURSABLE COST CENTERS 70 00 07000 HOME HEALTH AGENCY COST 823, 068 823, 068 70.00 07100 AMBULANCE 0 71.00 0 C 0 0 71.00 72.00 07200 CORF 0 C 0 0 0 72.00 72.10 07210 OPT 0 613, 785 0 613, 785 72.10 0 o 07300 CMHC C 73.00 73.00 C 0 07400 OTHER REIMBURSABLE COST 74.00 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 H0SPI CE 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 84.00 0 89 00 SUBTOTALS (sum of lines 1-84) 0 57, 082 12, 881, 002 0 12, 881, 002 89 00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 92 00 0 92 00 Ω 0 93.00 09300 NONPALD WORKERS 0 0 93.00 09400 PATIENTS LAUNDRY 0000 0 94.00 94.00 0 95.00 09500 OTHER NONREIMBURSABLE COST 1.368.816 50, 833, 403 50, 833, 403 95.00 3, 479, 824 09501 MARKETI NG 3, 479, 824 95 01 95.01 C 0 98.00 Cross Foot Adjustments 98.00 C C 0 99.00 Negative Cost Centers 99.00 67, 194, 229 100.00 TOTAL 1, 425, 898 67, 194, 229 100. 00

Health Financial Systems CONTINUING CARE AT SEABROOK VILLAGE In Lieu of Form CMS-2540-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315469 Period: Worksheet B From 01/01/2021 To 12/31/2021 Date/Time Prepared: 9/7/2022 1: 37 pm

CAPITAL RELATED COSTS

					10	12/31/2021	9/7/2022 1: 37	
				CAPI TAL REI	LATED COSTS			
			D	DI DOC. A	MOVARI E		EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
			Capi tal	TIATURES	LQUIFWLINI		DLINLITIS	
			Related Costs					
			0	1.00	2.00	2A	3. 00	
4 00		AL SERVICE COST CENTERS	T					1 00
1. 00 2. 00	1	CAP REL COSTS - BLDGS & FLXTURES CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	1	EMPLOYEE BENEFITS	0	0	0	o	0	1
4. 00	1	ADMINISTRATIVE & GENERAL		0		Ö	0	
5.00		PLANT OPERATION, MAINT. & REPAIRS	0	0	0	O	0	5. 00
6.00		LAUNDRY & LINEN SERVICE	0	0	0	0	0	
7. 00	1	HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	1	DI ETARY	0	0	0	0	0	8. 00
9. 00 10. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
11. 00	1	PHARMACY		0		0	0	
12. 00	1	MEDICAL RECORDS & LIBRARY	o	0		o	0	
13.00		SOCIAL SERVICE	0	0	0	O	0	1
14.00		NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	-	ACTIVITIES	0	0	0	0	0	15. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS		700 022	47 100	020 055	0	20.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	0	780, 932 0		828, 055 0	0	
32.00		ICF/IID		0		ol	0	
33. 00		OTHER LONG TERM CARE	o	0		o	0	
	-	LARY SERVICE COST CENTERS	· 1			- 1		
40.00		RADI OLOGY	0	0		0	0	40. 00
41.00		LABORATORY	0	0	0	0	0	41.00
42. 00	1	I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00 44. 00	1	OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0	0		0	0	
45. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	
46. 00	1	SPEECH PATHOLOGY	Ö	0	Ō	Ö	0	46. 00
47.00	04700	ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0	0	ol ol	0	50. 00 51. 00
52. 00	1	OTHER ANCILLARY SERVICE		0	1 1	ol Ol	0	1
02.00		TIENT SERVICE COST CENTERS	91		<u> </u>	<u> </u>		02.00
60.00	06000	CLI NI C	0	0	0	0	0	60.00
61. 00		RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200			0			0	62.00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	0	0	0	0	0	63.00
70. 00		HOME HEALTH AGENCY COST	O	12, 495	754	13, 249	0	70.00
71.00	1	AMBULANCE	0	0		0	0	1
72. 00	07200	CORF	0	0	0	0	0	72. 00
72. 10	07210		0	14, 942	1	15, 844	0	
73. 00 74. 00	07300	l e e e e e e e e e e e e e e e e e e e	0	0		0	0	1
74.00		OTHER REIMBURSABLE COST AL PURPOSE COST CENTERS	l d	U	<u> </u>	U	0	74.00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00		INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW						82. 00
83. 00		HOSPI CE	0	0	0	0	0	
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	909 340	10 770	0 857, 148	0	1
69.00	NONRE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS	l ol	808, 369	48, 779	037, 140	0	09.00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	ol	0	0	O	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	o	0	0	О	0	91.00
92. 00		PHYSICIANS PRIVATE OFFICES	0	0	0	o	0	1
93.00	1	NONPALD WORKERS	0	0	0	0	0	1
94.00	1	PATIENTS LAUNDRY	0	10 400 422	1 127 744	10 017 170	0	
95. 00 95. 01	1	OTHER NONREIMBURSABLE COST MARKETING		18, 689, 433 0	1, 127, 746	19, 817, 179 0	0	1
98. 00	0,301	Cross Foot Adjustments		0		ol	0	98. 00
99. 00		Negative Cost Centers		0	0	ō	0	1
100.00)	TOTAL	o	19, 497, 802	1, 176, 525	20, 674, 327	0	100. 00

Health Financial Systems CONTINUING CARE AT SEABROOK VILLAGE In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315469 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 9/7/2022 1: 37 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 4.00 7.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 0000000000 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 0 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 0 0 0 0 0 0 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 Λ 11.00 01100 PHARMACY 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 01300 SOCIAL SERVICE 0 13.00 13.00 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 C 0 14.00 15.00 01500 ACTI VI TI ES 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 SKILLED NURSING FACILITY 30.00 n O 0 0 0 03100 NURSING FACILITY 31.00 0 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 0 40.00 41.00 04100 LABORATORY 0000000000 0 0 0 0 0 0 0 0 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY 0 0 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 0 45.00 04600 SPEECH PATHOLOGY 0 46 00 46 00 0 04700 ELECTROCARDI OLOGY 0 47.00 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 0 51.00 05100 SUPPORT SURFACES C 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE ol 52.00 0 52.00 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0 60.00 60.00 0 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 63.00 0 0 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 0 0 71.00 07100 AMBULANCE 0 0 0 71.00 07200 CORF 72.00 0 0 0 72.00 0 0 0 72.10 07210 OPT 0 0 72.10 73.00 07300 CMHC 0 0 0 0 73.00 07400 OTHER REIMBURSABLE COST 74.00 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 83.00 08300 H0SPI CE 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 C 0 0 0 84.00 SUBTOTALS (sum of lines 1-84) 0 89.00 89.00 0

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0 90.00

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0 94.00

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0 98.00

0 99.00

91.00

92.00

93.00

95.01 0

0 100.00

90.00

91.00

92.00

93.00

94.00

95.00

95 01

98.00

99.00

100.00

NONREIMBURSABLE COST CENTERS

09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

09501 MARKETI NG

TOTAL

09200 PHYSICIANS PRIVATE OFFICES

09500 OTHER NONREIMBURSABLE COST

Cross Foot Adjustments

Negative Cost Centers

09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315469

						9/7/2022 1:37	pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		0.00	SUPPLY	11 00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9.00	10. 00	11.00	12. 00	13.00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSING ADMINISTRATION	0					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		0				10.00
11. 00	01100 PHARMACY	0	0	o l			11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0		12.00
13. 00	01300 SOCI AL SERVI CE	0	0		0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	o o	14. 00
15. 00	01500 ACTIVITIES	0	0	ol o	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			-	-		
30.00	03000 SKILLED NURSING FACILITY	0	O	0	0	0	30.00
31.00	03100 NURSING FACILITY	o	0	ol o	0	0	31.00
32.00	03200 CF/IID	o	0	ol o	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	o	0	ol o	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	<u>'</u>				•	
40.00	04000 RADI OLOGY	0	C	0	0	0	40. 00
41.00	04100 LABORATORY	0	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	O	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	O	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	O	0	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	O	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	O	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	O	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	O	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE	0	0	0	0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72. 00	07200 CORF	0	0	0	0	0	72. 00
72. 10	07210 OPT	0	0	0	0	0	72. 10
73. 00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS					T	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW		_	_	_	_	82. 00
83. 00	08300 HOSPI CE	0	0		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	1	0	-	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	0) 0	0	0	89. 00
00.00	NONREI MBURSABLE COST CENTERS						00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	-	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	y o	0	0	92.00
93.00	09300 NONPALD WORKERS		0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	94.00
95. 00 95. 01	09500 OTHER NONREIMBURSABLE COST 09501 MARKETING	0	0		0	0	95. 00 95. 01
98. 00	Cross Foot Adjustments	0	0		0		98.00
98.00	Negative Cost Centers	0	0	0	^	0	98.00
100.00	1 1 9	0	0				100.00
100.00	PI I I I I I I	ı	U	ή υ	ı U	1 0	1100.00

| Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315469

						To 12/31/2021	Date/Time Pre 9/7/2022 1:37	
				OTHER GENERAL			77772022 1.07	
		Cook Cooks December	NUDCING AND	SERVI CE	Cultatatal	D+ C+ D	T-+-1	
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
			EDUCATI ON			riaj astilierres		
			14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	I	I	I	T	I	1.00
2. 00	1	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00		EMPLOYEE BENEFITS						3. 00
4.00	1	ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	1	HOUSEKEEPI NG						7.00
8.00	00800	DI ETARY						8. 00
9.00		NURSI NG ADMI NI STRATI ON						9.00
10. 00 11. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY						10. 00 11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY						12.00
13.00	1	SOCIAL SERVICE						13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	0	0				15. 00
30. 00		SKILLED NURSING FACILITY	0	0	828, 0	55 0	828, 055	30. 00
31.00	1	NURSING FACILITY	0	0		0 0	0	31.00
32.00	1	ICF/IID	0	0	1	0 0	0	1
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0		0 0	0	33.00
40. 00		RADI OLOGY	0	0		0 0	0	40. 00
41. 00		LABORATORY	0	0		0 0	0	
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	0	0		0	0	42. 00 43. 00
44.00	1	PHYSICAL THERAPY	0	0		0 0		
45. 00	1	OCCUPATI ONAL THERAPY	Ö	Ö		0 0	Ö	
46. 00		SPEECH PATHOLOGY	0	0		0 0	0	
47. 00 48. 00	1	ELECTROCARDIOLOGY	0	0		0	0	
49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		0		0 0	0	
50. 00		DENTAL CARE - TITLE XIX ONLY	0	Ö		0 0	0	50.00
51. 00		SUPPORT SURFACES	0	0	l .	0 0	0	
52. 00		OTHER ANCILLARY SERVICE TIENT SERVICE COST CENTERS	0	0	1	0 0	0	52. 00
60. 00		CLI NI C	0	0	1	0 0	0	60.00
61. 00		RURAL HEALTH CLINIC	0	0		0 0		61. 00
62. 00	06200							62.00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	0	0	1	0 0	0	63.00
70. 00		HOME HEALTH AGENCY COST	0	0	13, 2	49 0	13, 249	70. 00
71. 00	1	AMBULANCE	0	0		0 0	0	
72. 00	07200		0	0		0 0	15.044	
72. 10 73. 00	07300			0	15, 8	0 0		72. 10 73. 00
74. 00		OTHER REIMBURSABLE COST	0	0	1	0 0	0	
		AL PURPOSE COST CENTERS	1	T	1		1	
80. 00 81. 00	1	MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00		UTI LI ZATI ON REVI EW						82.00
83. 00	08300	HOSPI CE	0	0		0 0	0	83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	057.4	0 0	0	
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	0	0	857, 1	48 0	857, 148	89. 00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	1	BARBER AND BEAUTY SHOP	0	0		0 0	0	
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES	0	0		0	0	
93.00		NONPALD WORKERS PATIENTS LAUNDRY	0	n		0 0	0	1
95.00	1	OTHER NONREIMBURSABLE COST	0	Ö	19, 817, 1	79 0	19, 817, 179	1
95. 01	09501	MARKETI NG	0	0		0 0	0	
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers	0	0			0	
100.00		TOTAL		0	20, 674, 3	27 0		
		•	,	,		,		

Health Financial Systems CONTIL
COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315469 | Peri od: From 01/01/20

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

			Ť	0 12/31/2021	Date/Time Pre 9/7/2022 1:37	
	CAPITAL RE	LATED COSTS			77 17 2022 1. 37	Pili
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
2001 201121 2000 1 211 211	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM. COST)	
	1.00	2.00	SALARI ES) 3. 00	4A	4. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FLXTUI						1. 00 2. 00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPM 3.00 00300 EMPLOYEE BENEFITS	MEINT	1, 498, 065 0	22, 596, 484			3.00
4. 00 00400 ADMINISTRATIVE & GENERAL	C	o	2, 176, 430		62, 725, 552	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPA	AIRS C	0	1, 219, 792	0	2, 562, 817	5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE 7. 00 00700 HOUSEKEEPING	C	0	0	0	0	6. 00 7. 00
8. 00 00800 DI ETARY			169, 718	0	241, 382	8.00
9.00 00900 NURSING ADMINISTRATION	C	0	0	0	0	9. 00
10. 00 01000 CENTRAL SERVI CES & SUPPLY	C	0	0	0	0	10.00
11. 00 01100 PHARMACY 12. 00 01200 MEDI CAL RECORDS & LI BRARY			0	0	0	11. 00 12. 00
13. 00 01300 SOCIAL SERVICE	C	Ö	0	0	0	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUC	i i	0	0	0	0	14. 00
15. 00 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENT	EDS	0	1, 055, 778	0	1, 331, 070	15. 00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	60, 001	60, 001	5, 240, 257	0	9, 462, 814	30.00
31.00 03100 NURSING FACILITY	C		0	0	0	31.00
32. 00 03200 CF/IID	C		0	0	0	32.00
33. 00 O3300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	C	0	0	0	0	33. 00
40. 00 04000 RADI OLOGY	С	0	0	0	28, 931	40. 00
41. 00 04100 LABORATORY	C	0	0	0	11, 453	1
42. 00 04200 I NTRAVENOUS THERAPY 43. 00 04300 0XYGEN (I NHALATION) THERAPY	C	0	0	0	26, 169 8, 883	1
44. 00 04400 PHYSI CAL THERAPY			196, 099	0	264, 819	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	C	0	235, 789		305, 850	1
46. 00 04600 SPEECH PATHOLOGY	C	0	84, 282	0	109, 930	46.00
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PA	ATLENTS C		0	0	0 125, 640	47. 00 48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	C	Ö	0	0	158, 951	•
50.00 O5000 DENTAL CARE - TITLE XIX ONLY	C	0	0	0	0	50. 00
51. 00 05100 SUPPORT SURFACES 52. 00 05200 OTHER ANCILLARY SERVICE		0	0	0	153 0	51. 00 52. 00
OUTPATIENT SERVICE COST CENTERS		,1	0			32.00
60. 00 06000 CLI NI C	C	1	0	0	0	60. 00
61.00 06100 RURAL HEALTH CLINIC 62.00 06200 FOHC	C	0	0	0	0	61. 00 62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST	CENTER C	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS	SERVICE S		3			00.00
70.00 07000 HOME HEALTH AGENCY COST	960		526, 178			70.00
71. 00 07100 AMBULANCE 72. 00 07200 CORF	C	0	0	0	0	71. 00 72. 00
72. 10 07210 0PT	1, 148	1, 148	382, 067	0	571, 002	72. 10
73. 00 07300 CMHC	C	0	0	0	0	73. 00
74. 00 07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS		0	0	0	0	74. 00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LO	OSSES					80.00
81.00 08100 INTEREST EXPENSE						81. 00
82. 00 08200 UTI LI ZATI ON REVI EW			0			82.00
83. 00 08300 HOSPI CE 84. 00 08400 OTHER SPECI AL PURPOSE COST CEI	NTERS		0	0	0 0	83. 00 84. 00
89. 00 SUBTOTALS (sum of lines 1-84)	62, 109	62, 109	11, 286, 390	-4, 468, 677	15, 976, 553	89. 00
NONREI MBURSABLE COST CENTERS	0.4NT55N					
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & (91.00 09100 BARBER AND BEAUTY SHOP	CANTEEN	0	0	0	0	90. 00 91. 00
92. 00 09200 PHYSI CLANS PRI VATE OFFICES		Ö	0	0	0	92.00
93.00 09300 NONPALD WORKERS	C	0	0	0	0	93. 00
94. 00 09400 PATIENTS LAUNDRY 95. 00 09500 OTHER NONREIMBURSABLE COST	1, 435, 956	0 1, 435, 956	0 10, 432, 409	0	0 43, 500, 598	94. 00 95. 00
95. 00 09300 OTHER NONRET MBURSABLE COST 95. 01 09501 MARKETI NG	1, 435, 950	0 1, 435, 950	10, 432, 409 877, 685		3, 248, 401	
98.00 Cross Foot Adjustments			277, 222		2, 2 . 2,	98. 00
99.00 Negative Cost Centers	40 .07	4 477 55	, ,67 ,5			99.00
102.00 Cost to be allocated (per Wks	t. B, 19, 497, 802	1, 176, 525	6, 687, 654		4, 468, 677	102.00
103.00 Unit cost multiplier (Wkst. B,		0. 785363	0. 295960		0. 071242	
104.00 Cost to be allocated (per Wks			0		0	104. 00
Part II)	I	1			I	I

Health Financial Systems CONT	INUING CARE AT SEABROOK VILLAGE			In Lieu of Form CMS-2540-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2021 Fo 12/31/2021	Date/Time Pre	nared:
				10 12/31/2021	9/7/2022 1: 37	_pm
	CAPITAL REI	_ATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM. COST)	
	,	,	SALARI ES)			
	1.00	2. 00	3. 00	4A	4. 00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000	D	0. 000000	105. 00
11)						

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315469

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

12/31/2021 Date/Time Prepared: 9/7/2022 1:37 pm Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (SQUARE FEET) (MEALS SERVED) ADMINISTRATION OPERATI ON, MAINT. & (TOTAL PATI (TOTAL PATI REPAIRS ENT DAYS) (SQUARE FEET) ENT DAYS) 5.00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 1, 498, 065 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 0 7.00 8.00 00800 DI ETARY 0 558, 492 8.00 00900 NURSING ADMINISTRATION 0 0 9 00 0 0 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 10.00 11.00 01100 PHARMACY 0 0 11.00 0 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 0 01300 SOCIAL SERVICE 0 0 13 00 13 00 0 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 60,001 0 0 54, 465 0 30.00 03100 NURSING FACILITY 0 0 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 0 33 00 33.00 Ω 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 0 0 0 0 41.00 04100 LABORATORY 0 0 41.00 0000000000 0 04200 I NTRAVENOUS THERAPY 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 0 04600 SPEECH PATHOLOGY 46.00 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 49.00 0 49.00 0 0 0 50.00 C Λ 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 0 52.00 05200 OTHER ANCILLARY SERVICE 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 n 0 Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 63.00 0 0 Λ 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 960 C 70.00 07100 AMBULANCE 71.00 0 0 0 0 0 71.00 0 72.00 07200 CORF 0 C 0 0 72.00 72. 10 07210 OPT 1, 148 72.10 07300 CMHC C 0 0 0 73.00 73.00 07400 OTHER REIMBURSABLE COST 0 74.00 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 H0SPI CE 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 84.00 89 00 SUBTOTALS (sum of lines 1-84) 62 109 Ω 0 54, 465 0 89 00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 C 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 92 00 0 0 0 92 00 Ω 0 0 93.00 09300 NONPALD WORKERS 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 94.00 94.00 95.00 09500 OTHER NONREIMBURSABLE COST 1.435.956 0 504, 027 0 95.00 95.01 09501 MARKETI NG 0 95.01 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 0 102, 00 102.00 2, 745, 397 0 258, 579 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 1.832629 0.000000 0.000000 0.462995 0. 000000 103. 00 104.00 Cost to be allocated (per Wkst. B, 0 104.00 Part II) 105 00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 0.000000 105.00 111)

COST ALLOCATION - STATISTICAL BASIS Provider No.: 315469 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 9/7/2022 1:37 pm Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND ALLI ED HEALTH SERVICES & (TOTAL PATI RECORDS & **SUPPLY** ENT DAYS) LI BRARY (TOTAL PATI **EDUCATION** (TOTAL PATI (TOTAL PATI ENT DAYS) (TOTAL PATI ENT DAYS) ENT DAYS) ENT DAYS) 13.00 10.00 11.00 12.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 01100 PHARMACY 0 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 0 12.00 01300 SOCIAL SERVICE 0 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 0 0 0 0 30.00 03100 NURSING FACILITY 0 0 0 0 0 31.00 31.00 32.00 0 03200 | CF/IID 0 0 0 32.00 0 03300 OTHER LONG TERM CARE 0 0 33.00 0 0 33 00 Ω ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 40.00 0 0 41.00 04100 LABORATORY 0000000000 0 0 0 0 0 0 0 0 0 0 0 41.00 04200 INTRAVENOUS THERAPY 0 0 42 00 42 00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 0 04600 SPEECH PATHOLOGY 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 0 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 49.00 0 49.00 0 0 0 50.00 C Λ 50.00 05100 SUPPORT SURFACES 0 0 0 51.00 51.00 05200 OTHER ANCILLARY SERVICE 52.00 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 63.00 0 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST C 70.00 07100 AMBULANCE 0 71.00 71.00 0 0 0 0 0 0 72.00 07200 CORF C 0 0 72.00 72. 10 07210 OPT 0 0 0 72.10 0 o 73.00 07300 CMHC C 0 0 73.00 07400 OTHER REIMBURSABLE COST 0 74.00 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 H0SPI CE 0 C 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 0 Ω 0 0 0 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 90.00 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 92 00 0 92 00 Ω 0 0 93.00 09300 NONPALD WORKERS 0 0 93.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 94.00 0 0 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 95.00 95.01 09501 MARKETI NG 0 95.01 0 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 0 102.00 102.00 C Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 0. 000000 103. 00 104.00 Cost to be allocated (per Wkst. B, 0 104.00 Part II) 105 00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 0.000000 105.00 111)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet B-1 | To 12/31/2021 | Date/Time Prepared: | 9/7/2022 1: 37 pm Provi der No.: 315469

Cost Center Description				9/7/2022	1: 37 pm
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102.00		1 1			
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 105.00		1 9			
103.00 Unit cost multiplier (Wkst. B, Part I) 3.144138 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 105.00	102.00	Cost to be allocated (per Wkst. B,	1, 425, 898		102. 00
104.00 Cost to be allocated (per Wkst. B, Part II) 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000000) 105.00		Part I)			
104.00 Cost to be allocated (per Wkst. B, Part II) 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000000) 105.00	103.00	1 1 '	3. 144138		103.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 105.00			1		•
105.00 Unit cost multiplier (Wkst. B, Part 0.000000 105.00		1 1]		
	105 00		0 000000		105 00
1 1112	. 55. 50		3. 300000		1.00.00
		1 1.,1	1		

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provi der No.: 315469 Peri od: Worksheet C From 01/01/2021 12/31/2021 Date/Time Prepared: 9/7/2022 1:37 pm Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col. 2 1.00 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 30, 992 26, 276 1. 179479 40.00 41. 00 | 04100 | LABORATORY 12, 269 10, 266 1. 195110 41.00 28, 033 42. 00 04200 I NTRAVENOUS THERAPY 42, 928 0.653024 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 9, 516 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 283, 685 502, 504 0.564543 44.00 45. 00 04500 OCCUPATIONAL THERAPY 327, 639 564, 187 0.580728 45.00 46. 00 04600 SPEECH PATHOLOGY 0.532708 117, 762 221, 063 46.00 47. 00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 134, 591 2, 753 48. 888849 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 170, 275 49.00 138, 210 1. 232002 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0.000000 O 0 50.00 51.00 05100 SUPPORT SURFACES 164 0 0.000000 51.00 52.00 05200 OTHER ANCILLARY SERVICE 0 0 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0.000000 60.00 06000 CLI NI C 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00

62.00

63.00

71.00

100.00

0.000000

0.000000

0

0

1, 508, 187

0

1, 114, 926

62. 00 06200 FQHC

100.00

71. 00 | 07100 | AMBULANCE

Total

63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre 9/7/2022 1:37	epared: 7 pm
		Title	XVIII (1)	Skilled Nursing		
	•			Facility		
		Heal th Care Pr	rogram Charges	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1. 00	2.00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					
ANCILLARY SERVICE COST CENTERS	T				_	
40. 00 04000 RADI OLOGY	1. 179479			0 13, 874	•	
41. 00 04100 LABORATORY	1. 195110			0 1, 600		
42.00 04200 INTRAVENOUS THERAPY 43.00 04300 OXYGEN (INHALATION) THERAPY	0. 653024 0. 000000	32, 197 0		0 21, 025	0	
43.00 04300 0XYGEN (I NHALATI ON) THERAPY 44.00 04400 PHYSI CAL THERAPY	0. 564543			0 143, 708		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 580728			0 168, 015	•	
46.00 04600 SPEECH PATHOLOGY	0. 532708			0 58, 427	0	1
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 30, 427	0	1
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	48. 888849			0	o o	
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 232002	101, 322		0 124, 829		
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0	1	50.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0	0	51.00
52. 00 05200 OTHER ANCILLARY SERVICE	0. 000000			0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	- 1		0	0	1
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of Lines 40 - 71)		800, 175		0 531, 478	0	100. 00

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

Heal th	Financial Systems CON	ΓΙΝUING CARE AT	SEABROOK VILLA	AGE	In Lie	eu of Form CMS-2	2540-10
APPORTI	ONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315469	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 9/7/2022 1:37	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description						
	PART II - APPORTIONMENT OF VACCINE COST					1. 00	
1.00	Drugs charged to patients - ratio of co	ost to charges	(From Workshee	t C column 3	line 49)	1. 232002	1.00
2. 00	Program vaccine charges (From your reco			t o, coramir o	, 11110 17)	0	1
3. 00	Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	Ō	
	E, Part I, line 18)	,					
	Cost Center Description	Total Cost	Nursing &	Ratio of		Part A Nursing	
			Allied Health		Cost (From	& Allied	
		· ·	(From Wkst. B,			Health Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part		Through (Col.	
				(Col . 2 / Col 1)	•	3 x Col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS					5.55	
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	30, 992	C	0.00000	00 13, 874	0	40. 00
41.00	04100 LABORATORY	12, 269	C	0.00000	1, 600	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	28, 033	C	0.00000	21, 025	0	42. 00
	04300 OXYGEN (INHALATION) THERAPY	9, 516		0.00000		0	43. 00
	04400 PHYSI CAL THERAPY	283, 685		0.00000		l e	44. 00
	04500 OCCUPATI ONAL THERAPY	327, 639		0.00000		0	45. 00
	04600 SPEECH PATHOLOGY	117, 762		0.00000		0	
	04700 ELECTROCARDI OLOGY	124 501		0.00000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	134, 591 170, 275		0.00000 0.00000		0	
	05000 DENTAL CARE - TITLE XIX ONLY	170, 275		0.00000			
	05100 SUPPORT SURFACES	164		0.00000		0	
	05200 OTHER ANCILLARY SERVICE	104		0.00000		0	
100.00	Total (Sum of lines 40 - 52)	1, 114, 926		•	531, 478		100.00
	1	1 ., , , 20	1	1	1 22.7 170	'	, ,,,,,

MPUTA	TION OF INPATIENT ROUTINE COSTS	Provi der No.: 315469	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 9/7/2022 1:37	pare
		Title XVIII	Skilled Nursing Facility	PPS	
			raciiity	1.00	
E	ART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	NPATIENT DAYS				t
00	npatient days including private room days			18, 155	1.
	Private room days			0	2
	npatient days including private room days applicable to the P			3, 691	3
	Medically necessary private room days applicable to the Program	m		0	1 '
_	Fotal general inpatient routine service cost			10, 329, 223	5
_	RIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			9, 711, 317	6
	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 d	ivided by line 6)		1. 063627	
	Enter private room charges from your records	TVI dea by Time of		0.000027	
	Average private room per diem charge (Private room charges line	e 8 divided by private	room days, line	0.00	
:	2)	3 1	3 .		
	Enter semi-private room charges from your records			0	
	Average semi-private room per diem charge (Semi-private room	charges line 10, divide	d by	0. 00	11
- 1	semi-private room days)	alina 11)		0.00	1:
	Average per diem private room charge differential (Line 9 minu: Average per diem private room cost differential (Line 7 times			0.00	
	Private room cost differential adjustment (Line 2 times line 1			0.00	1
	General inpatient routine service cost net of private room cos		minus line 14)	10, 329, 223	
	ROGRAM INPATIENT ROUTINE SERVICE COSTS		,		
00	Adjusted general inpatient service cost per diem (Line 15 div	ided by line 1)		568. 95	16
	Program routine service cost (Line 3 times line 16)			2, 099, 994	
	Medically necessary private room cost applicable to program (0	
	Total program general inpatient routine service cost (Line 17			2, 099, 994	
	Capital related cost allocated to inpatient routine service comine 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	SIS (From WKSI. B, Par	T II COLUMN 18,	828, 055	20
	Per diem capital related costs (Line 20 divided by line 1)			45. 61	2
	Program capital related cost (Line 3 times line 21)			168, 347	
	npatient routine service cost (Line 19 minus line 22)			1, 931, 647	
00	Aggregate charges to beneficiaries for excess costs (From pro	vider records)		0	24
	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	1, 931, 647	
	Enter the per diem limitation (1)				26
	npatient routine service cost limitation (Line 3 times the per				27
	Reimbursable inpatient routine service costs (Line 22 plus th (Transfer to Worksheet E, Part II, line 4) (See instructions)	e lesser of line 25 or	11ne 27)		28
	es 26 and 27 are not applicable for title XVIII, but may be us	ed for title V and or t	itle XIX		ı
	25 25 and 27 are not appropality for this Arrive but may be de				
				1. 00	
	ART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		40.455	١.
	Total SNF inpatient days			18, 155	
	Program inpatient days (see instructions) Fotal nursing & allied health costs. (see instructions)(Do not	complete for titles V	or VIV)	3, 691 0	
	Nursing & allied health ratio. (line 2 divided by line 1)	complete for titles v	υι <i>λ</i> Ι <i>λ)</i>	0. 203305	
J 1	varioring a arriva nearth ratio. (Trile 2 arviaca by fille 1)			0. 200000	1 ~

Health Financial Systems	CONTINUING CARE AT SEAE	BROOK VILLAGE	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLE	MENT FOR TITLE XVIII	Provi der No.: 315469	From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Prepared: 9/7/2022 1:37 pm
		Title XVIII	Skilled Nursing	PPS
			Facility	

		Title XVIII	Skilled Nursing	PPS	•
			Facility		
				1 00	
	DADT A LANDATION OF DEC DECULED COMPUTATION OF DEIMBURG	EMENT		1. 00	
1. 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS Inpatient PPS amount (See Instructions)	EMENI		2, 351, 940	1. 00
2. 00	Nursing and Allied Health Education Activities (pass through pa	vmonts)		2, 351, 940	2. 00
3. 00	Subtotal (Sum of lines 1 and 2)	ymerrts)	ł	2, 351, 940	3. 00
4. 00	Primary payor amounts			2, 331, 940	4. 00
5.00	Coi nsurance			281, 960	5. 00
6. 00	Allowable bad debts (From your records)			201, 700	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		ő	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)	Ct 013)		ő	8. 00
9. 00	Recovery of bad debts - for statistical records only			ő	9. 00
10. 00	Utilization review			o o	10. 00
11. 00	Subtotal (See instructions)			2, 069, 980	11. 00
12. 00	Interim payments (See instructions)			2, 069, 980	12. 00
13. 00	Tentati ve adjustment			0	13. 00
14. 00	OTHER adjustment (See instructions)		İ	o	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			o	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			o	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			o	14. 99
15.00	Balance due provider/program (see Instructions)			o	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2, s	section 115.2)	o	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - 7	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	17.00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)	a with CMC Dub 15 2	200+i on 11F 2	0	29. 00 30. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2, S	section 115.2	0	3U. UU

Health Financial Systems	CONTI NUI NG	CARE AT SEAB	ROOK VILLAGE	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT	SETTLEMENT TITLE V and TITLE	XIX ONLY	Provi der No.: 315469	From 01/01/2021 To 12/31/2021	Worksheet E Part II Date/Time Prepared: 9/7/2022 1:37 pm
			Title XIX	Skilled Nursing	Cost

		Title XIX	Facility	COST	
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES			1.00	
1.00	Inpatient ancillary services (see Instructions)			0	1.00
2. 00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2.00
3.00	Outpatient services	3)		0	3.00
4. 00	Inpatient routine services (see instructions)			0	4.00
5. 00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5.00
6. 00	Cost of covered services (Sum of Lines 1 - 5)	oi us)		0	6. 00
7. 00	Differential in charges between semiprivate accommodations and	Lass than saminrivata	accommodations	0	7. 00
8. 00	SUBTOTAL (Line 6 minus line 7)	ress than semi private	accollilloua (1 0115	0	8.00
9. 00	Primary payor amounts			0	9.00
10. 00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00
10.00	REASONABLE CHARGES			U	10.00
11. 00	Inpatient ancillary service charges			0	11. 00
12. 00	Outpatient service charges			0	12.00
13. 00	Inpatient routine service charges			0	13.00
14. 00	Differential in charges between semiprivate accommodations and	Loss than somingivato	accommodations	0	14.00
	Total reasonable charges	ress than semi private	accollilloua (1 0115	0	15. 00
15.00	CUSTOMARY CHARGES			U	15.00
16. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	16. 00
17. 00	Amounts that would have been realized from patients liable for			0	17. 00
17.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services e	in a charge basis	O	17.00
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	18. 00
19. 00				0	19.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
20. 00	Cost of covered services (see Instructions)			0	20. 00
21. 00	Deducti bl es			0	21. 00
22. 00	Subtotal (Line 20 minus line 21)			0	22. 00
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	24. 00
25. 00	Allowable bad debts (from your records)			0	25. 00
26. 00	Subtotal (sum of lines 24 and 25)			0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	y collected based on c	orrection of	0	27. 00
	cost limit				
28.00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	program	0	28. 00
	utilization				
29.00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	eciable assets (0	30. 00
	if minus, enter amount in parentheses)				
31. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	Interim payments			0	32. 00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0	33. 00
	Instructions)				

Health Financial Systems CONTINUIN ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2540-10 Provi der No.: 315469 Peri od: Worksheet E-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 9/7/2022 1:37 pm Title XVIII Skilled Nursing PPS

		11 (1	e AVIII	Facility	PPS	
		Inpatien	t Part A		rt B	
		,,,,,				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Total interim payments poid to provide	1. 00	2.00	3. 00	4. 00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		2, 069, 980		0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for		U			2.00
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				,	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Dravidar to Dragram		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADJUSTIMENTS TO FROUKAWI		0			3. 51
3. 52			0			3. 52
3. 53			ő			3. 53
3. 54			0		0	3. 54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		0		0	3. 99
	- 3.98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 069, 980		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			o o		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5.51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) PROGRAM TO PROVIDER		0		0	6. 01
6. 02	PROVI DER TO PROGRAM		0			6. 02
7. 00	Total Medicare program liability (see instructions)		2, 069, 980			7. 00
7.00	Total modification program frability (300 fractivetrons)		Contract		Contractor	7.00
					Number	
			1.	00	2. 00	
8.00	Name of Contractor		Novitas Soluti	ons	12001	8. 00
(1) On	lines 2 5 and 6 where an amount is due provider to progr	om chow the e	mount and data	on which the	nnavi dan	

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

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

Provi der No.: 315469 Peri od:

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 9/7/2022 1: 37 pm

oni y)			,	12, 31, 2321	9/7/2022 1: 37	7 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
1	Assets	1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1	Cash on hand and in banks	5, 631, 490	1	1	0	
1	Temporary investments	135, 493	1		_	
	Notes recei vabl e Accounts recei vabl e	2, 298, 600 2, 444, 931		1	0	
4	Other receivables	2, 444, 751		1	0	
4	Less: allowances for uncollectible notes and accounts	-569, 635	0	, o	0	
1	recei vabl e		_	_	_	
4	Inventory Prepaid expenses	178, 973 472, 971	1		0	
4	Other current assets	15, 369, 409			0	
4	Due from other funds	0	ō	o o	0	
	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	25, 962, 232	2 0	0	0	11.0
	FIXED ASSETS	1/ 7/0 00/	ıl c	1 0		12.0
	Land Land improvements	16, 749, 004 3, 265, 708	1		_	
	Less: Accumulated depreciation	-760, 545	1	1	-	
4	Bui I di ngs	309, 338, 540	1		0	
	Less Accumulated depreciation	-117, 836, 332		1	0	
	Leasehold improvements	16, 506		1	0	
4	Less: Accumulated Amortization Fixed equipment	-16, 506 1, 326, 495		1	0	
4	Less: Accumulated depreciation	-527, 706			0	
	Automobiles and trucks	953, 783	1	1	Ö	
22. 00	Less: Accumulated depreciation	-880, 486	0	o	0	22.0
1	Major movable equipment	5, 015, 957		1	0	
1	Less: Accumulated depreciation	-3, 063, 222	0	0	0	
	Minor equipment - Depreciable Minor equipment nondepreciable				0	
	Other fixed assets	8, 958, 968	1	1	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	222, 540, 164	1 0	0	0	28.0
	OTHER ASSETS	T	т			٠
4	Investments	68, 289, 635	1	1	0	
1	Deposits on Leases Due from owners/officers			1	0	
4	Other assets	636, 398	1	1 1	0	
	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	68, 926, 033	1	o	0	
-	TOTAL ASSETS (Sum of lines 11, 28, and 33)	317, 428, 429	9 0	0	0	34.0
-	Liabilities and Fund Balances CURRENT LIABILITIES					-
	Accounts payable	2, 152, 254	1 0	ol ol	0	35. 0
	Salaries, wages, and fees payable	2, 196, 142		1	_	
	Payroll taxes payable	510, 571		, o	0	
	Notes & Loans payable (Short term)	1, 337, 071		0	0	
	Deferred income Accelerated payments	51, 915	<u>'</u>	0	0	39. 0 40. 0
	Due to other funds	-1, 137, 538	3 0	ار	0	
1	Other current liabilities	277, 476, 625	1	1		1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	282, 587, 040	1	0	0	
_	LONG TERM LIABILITIES	1				
1	Mortgage payable	99, 106, 331			0	
1	Notes payable Unsecured Loans	99, 100, 331			0	
1	Loans from owners:		o o	ol ol	Ö	
48. 00	Other long term liabilities	0	0	o	0	48.0
	OTHER (SPECIFY)	0	0	1	0	
	TOTAL LONG TERM LIABILITIES (Sum of lines 44 – 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	99, 106, 331 381, 693, 371		1	0	
	CAPITAL ACCOUNTS	301,093,371		l ol	0	31.0
	General fund balance	-64, 264, 942	2			52.0
53. 00	Specific purpose fund		0	,	I	53.0
1	Donor created - endowment fund balance - restricted			0	1	54.0
	Donor created - endowment fund balance - unrestricted			0	I	55. C
	Governing body created - endowment fund balance Plant fund balance - invested in plant			١	0	56. C 57. C
1	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				ı	55.0
	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-64, 264, 942	1	o	0	
	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	317, 428, 429	<i>i</i> l 0	ıl ol	0	60.0
	59)				1	

14.00

15.00

16.00

17.00

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider No.: 315469 Peri od: Worksheet G-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 9/7/2022 1:37 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period -61, 459, 801 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -2, 522, 354 2.00 3.00 Total (sum of line 1 and line 2) -63, 982, 155 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0000 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) -63, 982, 155 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 INTERCOMPANY ADJUSTMENT 282, 787 0 13.00 0 14.00 14.00 0 0 0 15.00 0 15.00 0 16.00 0 16.00 17.00 0 17.00 18.00 Total deductions (sum of lines 13 - 17) 282, 787 18.00 Fund balance at end of period per balance 19.00 -64, 264, 942 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 INTERCOMPANY ADJUSTMENT 13.00 13.00

0

0

0

0

0

14.00

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 13 - 17)

sheet (Line 11 - line 18)

Fund balance at end of period per balance

Health Financial Systems	CONTINUING CARE AT SEAB	ROOK VILLAGE		In	Lieu of Form CMS-2540-10
OTATEMENT OF BATLENT BEVENUES AN	ID ODEDATING EVERYORS	D 1 1 11	045440		

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Heal th	Financial Systems CONTINUING CARE AT SEA	BROOK VILLA	AGE	In Lie	eu of Form CMS-2	2540-10
PART I - PATIENT REVENUES General Inpatient Routine Care Services SKILLEN MUSSING FACILITY 9,711,317 9,711,317 0 2.00 0 3.00 1.00 0 0 3.00 0 0 3.00 0 0 0 3.00 0 0 0 0 3.00 0 0 0 0 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	STATEM		Provi der		From 01/01/2021 To 12/31/2021	Parts I-II Date/Time Pre	pared:
PART I - PATIENT REVENUES General Inpatient Routine Care Services		Cost Center Description					
Ceneral Inpatient Routine Care Services 1,00 1,317 1,01,317 1,00 2,00 1,				1. 00	2. 00	3. 00	
1.00							
2.00							
3.00				9, 711, 31	7		
4. 00 OTHER LONG TERM CARE Total general inpatient care services (Sum of lines 1 - 4) 9,711,317 75.00					0	1	
5.00 Total general inpatient care services (Sum of lines 1 - 4) 9,711,317 9,711,317 5.00 All Other Care Services 1,508,187 0 1,508,187 6.00 0 7.00 8.00 Mode HEALTH AGENCY COST 2,110,786 2,110,786 8.00 9.00 AMBULANCE 2,110,786 2,110,786 8.00 9.00 AMBULANCE 2,110,786 2,110,786 8.00 9.00 0.00 RURAL HEALTH CLINIC 0 0 0 10.00					0	0	
All Other Care Services					0	0	
6.00 AKCILLARY SERVICES CLINIC CLINIC RODE RODE RODE RODE RODE RODE RODE RODE	5.00			9, 711, 31	/	9, 711, 317	5.00
7.00 CLINIC 0 7.00 0.0				4 500 46	\ 7	4 500 407	
8.00 HOME HEALTH AGENCY COST				1, 508, 18	37		
9.00 AMBULANCE 10.00 RIBRAL HEALTH CLINIC 10.10 FOHC 11.00 CMHC 11.10 CORF 11.30 OPT 11.30 OPT 12.00 HOSPICE 0 0 0 0 11.10 13.00 TOTAL Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11,219,504 2,748,767 13,968,271 14.00 14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11,219,504 2,748,767 13,968,271 14.00 PART II - OPERATING EXPENSES 1.00 Add (Specify) 1.00 Cost Center Description PART II - OPERATING EXPENSES 1.00 Add (Specify) 1.00 Cost Center Description 1.00 Cost					2 110 704	-	
10.00 RURAL HEALTH CLINIC 0 0 10.00 10.10 FOHC 0 0 0 11.10 11.00 CMHC 0 0 0 11.10 11.30 OPT 637,981 637,981 637,981 11.30 12.00 HOSPICE 0 0 0 0 12.00 13.00 OTHER (SPECIFY) 0 0 0 0 13.00 14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11,219,504 2,748,767 13,968,271 14.00					2, 110, 786		
10. 10 FOHC 11. 10 CMHC 11. 10 CMHC 11. 10 CMHC 11. 10 CORF 0 0 11. 10 11. 10 CORF 0 0 11. 10 11. 10 CORF 0 0 0 11. 10 11. 10 CORF 0 0 0 11. 10 11. 10 CORF 0 0 0 12. 00 CMHC					0	1	
11.00 CMHC 0 0 0 11.00 11.10 CORF 0 0 0 11.10 11.30 OPT 637,981 637,981 11.30 12.00 HOSPICE 0 0 0 0 13.00 OTHER (SPECIFY) 0 0 0 0 13.00 14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11,219,504 2,748,767 13,968,271 14.00					0	1	
11. 10 CORF 11. 30 OPT 12. 00 HOSPI CE 0 HOSPI CE 0 TOTHER (SPECIFY) 14. 00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11, 219, 504 2, 748, 767 13, 968, 271 14. 00 PART II - OPERATING EXPENSES					0	0	
11. 30 OPT 12. 00 HOSPICE 0 0 0 0 12. 00 13. 00 OTHER (SPECIFY) 14. 00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11, 219, 504 2, 748, 767 13, 968, 271 14. 00 PART II - OPERATING EXPENSES					0	0	
12.00 HOSPICE 0 0 0 12.00 13.00 OTHER (SPECIFY) 14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11,219,504 2,748,767 13,968,271 14.00					427 001	427 001	
13.00 OTHER (SPECIFY) 14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11, 219, 504 2, 748, 767 13, 968, 271 14.00					037, 901		
14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 11, 219, 504 2, 748, 767 13, 968, 271 14.00					0		
Worksheet G-3, Line 1) Cost Center Description 1.00 2.00			to	11 210 50	0 2 740 767	-	
Cost Center Description 1.00 2.00	14.00	, , ,	10	11, 217, 30	2, 740, 707	13, 700, 271	14.00
PART II - OPERATING EXPENSES 1.00 2.00				l			
PART II - OPERATING EXPENSES		300 t 300 to 1 p t 1 c 1			1. 00	2. 00	
2.00 Add (Specify) 0 2.00 3.00 4.00 5.00 6.00 7.00 8.00 7.00 8.00 11.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 14.00 10.00 14.00 10.00 10.00 14.00 10.00		PART II - OPERATING EXPENSES					
2.00 Add (Specify) 0 2.00 3.00 4.00 5.00 6.00 7.00 8.00 7.00 8.00 11.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 14.00 10.00 14.00 10.00 10.00 14.00 10.00	1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				70, 929, 275	1. 00
4.00 5.00 6.00 7.00 8.00 Total Additions (Sum of lines 2 - 7) Deduct (Specify) 0 10.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13)	2.00				0		2. 00
5.00 6.00 7.00 8.00 Total Additions (Sum of lines 2 - 7) Deduct (Specify) 0 10.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 5.00 6.00 7.00 8.00 7.00 9.00 10.00 11.00 11.00 12.00 13.00	3.00				0		3. 00
6.00 7.00 8.00 Total Additions (Sum of lines 2 - 7) 9.00 Deduct (Specify) 0 9.00 11.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 6.00 7.00 7.00 9.00 10.00 11.00 11.00 12.00 13.00	4.00				0		4. 00
7.00 8.00 Total Additions (Sum of lines 2 - 7) 9.00 Deduct (Specify) 0 0 10.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 7.00 0 8.00 0 9.00 10.00 11.00 0 11.00 0 12.00 0 12.00	5.00				0		5. 00
8.00 Total Additions (Sum of lines 2 - 7) 0 8.00 9.00 10.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 14.00 10 10 10 10 10 10 10	6.00				0		6.00
9.00 Deduct (Specify) 0 9.00 10.00 11.00 11.00 12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 14.00 14.00 10 10 10 10 10 10 10	7.00				0		7. 00
10.00	8.00					0	8. 00
11. 00 12. 00 13. 00 14. 00 Total Deductions (Sum of lines 9 - 13) 0 11. 00 0 12. 00 13. 00 14. 00 Total Deductions (Sum of lines 9 - 13)	9.00				0		9. 00
12.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 14.00	10.00				0		10.00
13.00 14.00 Total Deductions (Sum of lines 9 - 13) 0 14.00	11. 00				0		11. 00
14.00 Total Deductions (Sum of lines 9 - 13) 0 14.00					0		
					0		13. 00
15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14) 70,929,275 15.00		,				_	
	15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				70, 929, 275	15. 00

STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315469	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Prep 9/7/2022 1:37	pared:
				1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, lin			13, 968, 271	1.0
2. 00	Less: contractual allowances and discounts on patients accou	nts		3, 459, 547	2. 0
3. 00	Net patient revenues (Line 1 minus line 2)			10, 508, 724	3. 0
4. 00	Less: total operating expenses (From Worksheet G-2, Part II,	line 15)		70, 929, 275	
5. 00	Net income from service to patients (Line 3 minus 4)			-60, 420, 551	5.0
	Other income:				
6. 00	Contributions, donations, bequests, etc			364, 666	6. 0
7. 00	Income from investments			5, 490, 799	7.0
3. 00	Revenues from communications (Telephone and Internet servic	e)		0	
9. 00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10.0
	Rebates and refunds of expenses			0	11.0
	Parking lot receipts			0	12.0
	Revenue from Laundry and Linen service			0	13.0
14.00	Revenue from meals sold to employees and guests			176, 915	
	Revenue from rental of living quarters			35, 510	15.0
6.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 0
7. 00	Revenue from sale of drugs to other than patients			0	17. C
8.00	Revenue from sale of medical records and abstracts			471	18. C
9.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.0
20.00	Revenue from gifts, flower, coffee shops, canteen			124, 139	20. C
21. 00	Rental of vending machines			1, 823	21.0
2.00	Rental of skilled nursing space			0	22. C
3.00	Governmental appropriations			0	23. C
	Other miscellaneous revenue (specify)			51, 703, 874	24. C
24. 50	COVI D-19 PHE Funding			0	24.5
25. 00	Total other income (Sum of lines 6 - 24)			57, 898, 197	25. C
	Total (Line 5 plus line 25)			-2, 522, 354	26.0
	Other expenses (specify)			0	
8. 00				0	28.0
9. 00				0	
	Total other expenses (Sum of Lines 27 - 29)			0	
	Net income (or loss) for the period (Line 26 minus line 30)			-2, 522, 354	31.0

THATLIC	SIS OF SNF-BASED HOME HEALTH AGENCY COSTS		Provi der	No.: 315469	Peri od:	Worksheet H	
			HHA CCN:	317093	From 01/01/2021 To 12/31/2021	Date/Time Pre 9/7/2022 1:37	
					Home Health Agency I	PPS	piii
		Sal ari es	Empl oyee	Transportatio	on Contracted/Pur	Other Costs	
			Benefits	(see	chased		
		1.00	2.00	instructions 3.00) Services 4.00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment				0	0	1. 00 2. 00
3. 00	Plant Operation & Maintenance	0	0		0 0	_	3. 00
4.00	Transportation (see instructions)	0	0		0 0	Ō	4. 00
5.00	Administrative and General	201, 130	0		0 0	103, 839	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	137, 782	0		0 0	0	6. 00
7. 00	Physical Therapy	91, 016	Ö		0 0		7. 00
8.00	Occupational Therapy	77, 391	0		0	0	8. 00
9.00	Speech Pathology	13, 811	0		0 0	0	9. 00 10. 00
10. 00 11. 00	Medical Social Services Home Health Aide	5, 048	0			0	11. 00
12. 00	Supplies (see instructions)	0	0		0 0	6, 562	
13. 00	Drugs	0	0		0 0	0	13. 00
14.00	DME	0	0		0	_	14.00
15. 00	Tel emedi ci ne HHA NONREI MBURSABLE SERVI CES	<u> </u>	0		0 0	0	15. 00
16. 00	Home Dialysis Aide Services	0	0		0 0	0	16. 00
17. 00	Respiratory Therapy	0	0		0 0		17. 00
18. 00 19. 00	Private Duty Nursing Clinic	0	0		0	0	18. 00 19. 00
20. 00	Health Promotion Activities	0	0			0	20.00
21. 00	Day Care Program	0	0		0 0	0	21. 00
22. 00	, ,	0	0		0 0	0	22. 00
23. 00 24. 00	Homemaker Service All Others (specify)	0	0			0	23. 00 24. 00
	Total (sum of lines 1-24)	526, 178	Ö		0 0	110, 401	
		Total (sum of R				Net Expenses	
			on	Trial Balanc	e	for Allocation	
		cols. 1 thru		(col 6 +			
		5)		(col. 6 + col.7)		(col . 8 + col . 9)	
	ACTUAL ASSUMAN ASSUMAN		7. 00		9. 00	(col. 8 + col.	
1 00	GENERAL SERVICE COST CENTERS Canital Related - Ridg & Fixtures	5)	7. 00	col . 7)	9.00	(col. 8 + col. 9)	
1.00	Capital Related - Bldg. & Fixtures	5)	7.00	col . 7)	9.00	(col. 8 + col. 9)	1. 00
2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance	5)	7. 00 0 0	col . 7)	9.00	(col. 8 + col. 9)	1. 00 2. 00 3. 00
2.00 3.00 4.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions)	6.00 0 0 0	0 0 0 0	col . 7) 8. 00	0 0 0 0 0 0 0 0	(col. 8 + col. 9) 10.00	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General	5)	7. 00 0 0 0 0	col . 7)	0 0 0 0 0 0 0 0	(col. 8 + col. 9) 10.00	1. 00 2. 00 3. 00
2.00 3.00 4.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions)	6.00 0 0 0	0 0 0 0	col . 7) 8. 00	0 0 0 0 0 0 0 0 0 0 -38,867	(col . 8 + col . 9) 10.00 0 0 0 266, 102	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	5) 6.00 0 0 0 304,969 137,782 91,016	0 0 0 0 0	304, 96 137, 78 91, 0	0 0 0 0 0 0 0 0 0 0 0 69 -38,867	(col . 8 + col . 9) 10.00 0 0 0 266, 102	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	5) 6.00 0 0 0 304,969 137,782 91,016 77,391	000000000000000000000000000000000000000	304, 96 137, 78 91, 07 77, 38	0 0 0 0 0 0 0 0 0 0 0 69 -38,867	(col . 8 + col . 9) 10.00 0 0 0 266, 102 137, 782 91, 016 77, 391	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	5) 6.00 0 0 0 304,969 137,782 91,016	0 0 0 0 0	304, 96 137, 78 91, 0	0 0 0 0 0 0 0 0 0 0 0 69 -38,867	(col . 8 + col . 9) 10.00 0 0 0 266, 102	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	5) 6.00 0 0 0 304,969 137,782 91,016 77,391	0 0 0 0 0	304, 96 137, 78 91, 0' 77, 39 13, 8'	0 0 0 0 0 0 0 0 0 0 99 -38,867	(col . 8 + col . 9) 10.00 0 0 0 266, 102 137, 782 91, 016 77, 391	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562	0 0 0 0 0	304, 96 137, 78 91, 07 77, 38 13, 8°	0 0 0 0 0 0 0 0 0 0 99 -38,867	(col . 8 + col . 9) 10.00 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0	0 0 0 0 0 0 0 0	304, 96 137, 78 91, 0 77, 39 13, 8° 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10.00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 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
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562	0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 99 -38,867	(col . 8 + col . 9) 10. 00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0 0 0	0 0 0 0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10. 00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0	0 0 0 0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10.00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 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
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0 0 0	0 0 0 0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10.00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 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
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0 0 0	0 0 0 0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10.00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 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 20. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0 0 0	0 0 0 0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10. 00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 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 17. 00 18. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0 0 0	0 0 0 0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10. 00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 0 0 0 0 0 0 0 0 0 0 0 0 0 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 20. 00 21. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0 0 0	0 0 0 0 0 0 0 0	304, 96 304, 96 137, 78 91, 07 77, 39 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10. 00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation (see instructions) Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Telemedicine HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	5) 6.00 0 0 0 304,969 137,782 91,016 77,391 13,811 0 5,048 6,562 0 0 0	0 0 0 0 0 0 0 0	304, 96 137, 78 91, 07 77, 38 13, 87 5, 04 6, 56	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col . 8 + col . 9) 10. 00 0 0 0 266, 102 137, 782 91, 016 77, 391 13, 811 0 5, 048 6, 562 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 20. 00 21. 00 22. 00 23. 00 24. 00

	ALLOCATION - HHA GENERAL SERVICE COST	THORNE GAME AT	Provi der	No.: 315469	Peri od:	Worksheet H-1	
			HHA CCN:	317093	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 9/7/2022 1:37	
					Home Health Agency I	PPS	рш
			Capital Re	ated Costs	Agency		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportati on	
		0	1. 00	2. 00	3. 00	4.00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. & Fixtures		0	I		I	1.00
2. 00	Capital Related - Blug. & Fixtures Capital Related - Movable Equipment	0	O		0		2.00
3.00	Plant Operation & Maintenance	0	0		0 0		3. 00
4. 00 5. 00	Transportation Administrative and General	266, 102	0		0 0		4. 00 5. 00
3.00	HHA REIMBURSABLE SERVICES	200, 102			0 0		3.00
6.00	Skilled Nursing Care	137, 782	0		0 0		
7. 00 8. 00	Physical Therapy Occupational Therapy	91, 016 77, 391	0		0 0		
9. 00	Speech Pathology	13, 811	0		0 0	Ö	9. 00
10.00	Medical Social Services	0	0		0 0	0	
11. 00 12. 00	Home Health Aide Supplies (see instructions)	5, 048 6, 562	0		0 0	0	11. 00 12. 00
13. 00	Drugs	0, 302	Ö		0 0	Ĭ	13. 00
14. 00	DME	0	0		0 0		
15. 00	Tel emedi ci ne HHA NONREI MBURSABLE SERVI CES	0	0		0 0	0	15. 00
16. 00	Home Dialysis Aide Services	0	0		0 0	0	16. 00
17. 00	Respiratory Therapy	0	0		0 0		17. 00
18. 00 19. 00	Private Duty Nursing Clinic	0	0		0 0	0	18. 00 19. 00
	Health Promotion Activities	O	0		0 0	0	1
21. 00		0	0		0 0	0	
22. 00	Home Delivered Meals Program Homemaker Service	0	0		0 0	0	22. 00 23. 00
24. 00	1	Ō	0		0 0	0	24. 00
25. 00	Total (sum of lines 1-24)	597, 712 Subtotal	0 Admi ni strati ve	Total (cols	0 0	0	25. 00
		(col s. 0-4)	& General	4A + 5)			
	GENERAL SERVICE COST CENTERS	4A. 00	5. 00	6. 00			
1. 00	Capital Related - Bldg. & Fixtures	0					1.00
2.00	Capital Related - Movable Equipment	0					2. 00
3. 00 4. 00	Plant Operation & Maintenance Transportation	0					3. 00 4. 00
5. 00	Administrative and General	266, 102	266, 102				5. 00
	HHA REIMBURSABLE SERVICES	407 700	440 5/0	040.0	45		, ,,
6. 00 7. 00	Skilled Nursing Care Physical Therapy	137, 782 91, 016	110, 563 73, 036				6. 00 7. 00
8. 00	Occupational Therapy	77, 391	62, 103	1			8. 00
9.00	Speech Pathol ogy	13, 811	11, 083	24, 89			9. 00
10. 00 11. 00	Medical Social Services Home Health Aide	5, 048	4, 051	9, 0	0		10. 00 11. 00
12. 00	Supplies (see instructions)	6, 562	5, 266				12.00
13.00		0	0		0		13.00
14. 00 15. 00	DME Tel emedi ci ne	0	0		0		14. 00 15. 00
	HHA NONREIMBURSABLE SERVICES	-	-		-1		
16.00	1	0	0		0		16.00
17. 00 18. 00	1	0	0		0		17. 00 18. 00
19. 00		O	0		Ö		19. 00
20.00	I and the second	0	0		0		20.00
	Day Care Program Home Delivered Meals Program		0		0		21. 00 22. 00
23. 00	Homemaker Service	o	0		0		23. 00
	All Others (specify) Total (sum of lines 1-24)	0 597, 712	0	597, 7°	0		24. 00 25. 00
25.00	Total (Suill Of TITIES 1-24)	391, 112		1 397, 7	14		₁ 25.00

10.00	Medical Social Services	0	0	0	o	0	10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	0	0	0	0	0	11. 00 12. 00
12.00	Drugs	0	0	0	U U	0	12.00
14. 00	DME		o	o	0	0	14. 00
15. 00	Tel emedi ci ne	l o	ő	Ö	Ö	0	
	HHA NONREIMBURSABLE SERVICES						
16. 00	Home Dialysis Aide Services	0	0	0	0	0	
17. 00	Respiratory Therapy	0	0	0	0	0	17. 00
18.00	Private Duty Nursing	0	0	0	O	0	18.00
19. 00 20. 00	Clinic	0	0	0	0	0	19. 00 20. 00
20.00	Health Promotion Activities Day Care Program		0	0	0	0	
22. 00	Home Delivered Meals Program		o	0	0	0	22. 00
23. 00	Homemaker Service		o	Ö	Ö	0	23. 00
24. 00	All Others (specify)	o	o	O	o	0	
25.00	Total (sum of lines 1-24)	960	960	0	o	-266, 102	25. 00
26. 00	Cost To Be Allocated	0	0	0	0		26. 00
27. 00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000		27. 00
		Administrative					
		& General (ACCUM. COST)					
		5. 00					
	GENERAL SERVICE COST CENTERS	0.00		·			
1.00	Capital Related - Bldg. & Fixtures						1. 00
2.00	Capital Related - Movable Equipment						2. 00
3.00	Plant Operation & Maintenance						3. 00
4.00	Transportation (see instructions)						4. 00
5.00	Administrative and General	331, 610					5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	137, 782					6. 00
7. 00	Physical Therapy	91, 016					7. 00
8.00	Occupational Therapy	77, 391					8. 00
9. 00	Speech Pathology	13, 811					9. 00
10.00	Medi cal Soci al Servi ces	0					10. 00
11. 00	Home Health Aide	5, 048					11. 00
12.00	Supplies (see instructions)	6, 562					12.00
13. 00	Drugs	0					13. 00
14.00	DME	0					14. 00
15. 00	Tel emedi ci ne HHA NONREI MBURSABLE SERVI CES	0					15. 00
16. 00	Home Dialysis Aide Services	0					16. 00
17. 00	Respiratory Therapy						17. 00
18. 00	Private Duty Nursing	o					18. 00
19. 00	Clinic	o					19. 00
20.00	Health Promotion Activities	0					20. 00
21. 00	Day Care Program	0					21. 00
22. 00	Home Delivered Meals Program	0					22. 00
23. 00 24. 00	Homemaker Service	0					23. 00 24. 00
25. 00	All Others (specify) Total (sum of lines 1-24)	331, 610					25. 00
26. 00	Cost To Be Allocated	266, 102					26. 00
27. 00	Unit Cost Multiplier	0. 802455					27. 00
	i transfer i						

Health Financial Systems CONTINUIN ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 9/7/2022 1:37 pm Provi der No.: 315469 Peri od: From 01/01/2021 To 12/31/2021 HHA CCN: 317093 Home Health PPS

				Agency I		
		CAPITAL REL	LATED COSTS			
Cost Center Description	HHA Trial	BLDGS &	MOVARI F	EMPLOYEE	Subtotal	
occi contor boson per on			7		oub roru.	
	0	1. 00	2. 00	3. 00	3A	
Administrative and General		12, 495	754	59, 526	72, 775	1.00
Skilled Nursing Care	248, 345	0	0	40, 778	289, 123	2. 00
Physi cal Therapy	164, 052	0	0	26, 937	190, 989	3. 00
Occupational Therapy	139, 494	0	0	22, 905	162, 399	4.00
Speech Pathology	24, 894	0	0	4, 088	28, 982	5. 00
Medical Social Services	0	0	0	0	0	6.00
Home Health Aide	9, 099	0	0	1, 494	10, 593	7. 00
Suppl i es	11, 828	0	0	0	11, 828	8. 00
Drugs	0	ol ol		0	0	9. 00
DME	0	0	0	0	0	10.00
Tel emedi ci ne	0	0	0	0	0	11. 00
Home Dialysis Aide Services	0	0	0	0	0	12. 00
Respi ratory Therapy	0	0	0	0	0	13. 00
Private Duty Nursing	0	0	0	0	0	14. 00
Clinic	0	0	0	0	0	15. 00
Health Promotion Activities	0	0	0	0	0	16. 00
Day Care Program	0	0	0	0	0	17. 00
Home Delivered Meals Program	0	0	0	0	0	18. 00
Homemaker Service	0	0	0	0	0	19. 00
All Others (specify)	0	0	0	0	0	20. 00
Total (sum of lines 1-20) (2)	597, 712	12, 495	754	155, 728	766, 689	21. 00
					0.000000	22. 00
divided by the sum of column 18, line 21						1
minus column 18, line 1, rounded to 6						l
decimal places.				l		1
	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies Drugs DME Telemedicine Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-20) (2) Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21	Administrative and General Skilled Nursing Care 248,345 Physical Therapy 164,052 Occupational Therapy 139,494 Speech Pathology 24,894 Medical Social Services 0 Home Health Aide 9,099 Supplies 11,828 Drugs 0 DME 0 Telemedicine 0 Home Dialysis Aide Services 0 Respiratory Therapy 0 Private Duty Nursing 0 Clinic 0 Health Promotion Activities 0 Day Care Program 0 Home Delivered Meals Program 0 Home Delivered Meals Program 0 Homemaker Service 1 All Others (specify) 0 Total (sum of lines 1-20) (2) 1 Unit Cost Multiplier: column 18, line 1 1 divided by the sum of column 18, line 21 1 minus column 18, line 1, rounded to 6	Administrative and General Skilled Nursing Care 248,345 0	Bal ance (1) FIXTURES EQUI PMENT	Administrative and General Skilled Nursing Care 248,345 0 0 22,905 Skilled Nursing Care 248,345 0 0 0 40,778 Physical Therapy 164,052 0 0 22,905 Speech Pathology 24,894 0 0 0 22,905 Speech Pathology 24,894 0 0 0 22,905 Speech Pathology 24,894 0 0 0 0 0 Home Health Aide 9,099 0 0 0 0 DME 0 0 0 0 0 DME 0 0 0 0 Celemedicine 0 0 0 0 Home Dialysis Aide Services 0 0 0 0 Home Dialysis Aide Services 0 0 0 0 Clinic 0 0 0 0 Health Promotion Activities 0 0 0 0 Day Care Program 0 0 0 0 Home Delivered Meals Program 0 0 0 0 Home Delivered Meals Program 0 0 0 0 Home Dialysis (specify) 0 0 0 0 Total (sum of lines 1-20) (2) 597,712 12,495 754 Inirus column 18, line 1, rounded to 6	CAPITAL RELATED COSTS BLDGS & MOVABLE EQUIPMENT EQUIPMENT BLDGS & FIXTURES BLDGS & BLDGS & FIXTURES BLDGS & FIXTURS BLD

(1) Column O, line 21 must agree with Wkst. A, column 7, line 70.(2) Columns O through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION,	LINEN SERVICE			
			MAINT. & REPAIRS				
		4.00	5. 00	6, 00	7. 00	8. 00	
1.00	Administrative and General	5, 185	1, 759		7.00	0.00	1, 00
2.00	Skilled Nursing Care	20, 597	1, 737	0	0	0	2.00
3.00	Physical Therapy	13, 606	0	0	0	o o	3.00
4. 00	Occupational Therapy	11, 569	0	o o	0	0	4. 00
5. 00	Speech Pathology	2, 065	0	0	0	0	5. 00
6.00	Medical Social Services	0	0	0	0	Ō	6.00
7.00	Home Health Aide	755	0	0	0	0	7. 00
8.00	Suppl i es	843	0	0	0	0	8. 00
9.00	Drugs	o	0	0	0	0	9. 00
10.00	DME	o	0	0	0	0	10.00
11.00	Tel emedi ci ne	o	0	0	0	0	11. 00
12.00	Home Dialysis Aide Services	o	0	0	0	0	12.00
13.00	Respi ratory Therapy	0	0	0	0	0	13.00
14.00	Private Duty Nursing	0	0	0	0	0	14. 00
15.00	Clinic	0	0	0	0	0	15. 00
16.00	Health Promotion Activities	0	0	0	0	0	16. 00
17.00	Day Care Program	0	0	0	0	0	17. 00
18.00	Home Delivered Meals Program	0	0	0	0	0	18. 00
19. 00	Homemaker Service	0	0	0	0	0	19. 00
20.00	All Others (specify)	0	0	0	0	0	20. 00
21. 00	Total (sum of lines 1-20) (2)	54, 620	1, 759	0	0	0	21. 00
22. 00	Unit Cost Multiplier: column 18, line 1						22. 00
	divided by the sum of column 18, line 21						
	minus column 18, line 1, rounded to 6						
	decimal places.						

(1) Column 0, line 21 must agree with Wkst. A, column 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11. 00	12.00	13.00	
1.00	Administrative and General	0	0	0	0	0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physi cal Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Heal th Aide	0	0	0	0	0	7. 00

Health Financial Systems CONTINUIN ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 9/7/2022 1:37 pm Provi der No.: 315469 Peri od: From 01/01/2021 To 12/31/2021 HHA CCN: 317093 Home Health PPS

					Agency I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11. 00	12.00	13.00	
8.00	Suppl i es	0	0		0 0	0	8. 00
9.00	Drugs	0	0		0 0	0	9. 00
10.00	DME	0	0		0 0	0	10.00
11. 00	Tel emedi ci ne	0	0		0 0	0	11.00
12.00	Home Dialysis Aide Services	0	0		0 0	0	12.00
13.00	Respi ratory Therapy	0	0		0 0	0	13.00
14.00	Private Duty Nursing	0	0		0 0	0	14.00
15.00	Clinic	0	0		0 0	0	15.00
16.00	Health Promotion Activities	0	0		0 0	0	16.00
17.00	Day Care Program	0	0		0 0	0	17.00
18.00	Home Delivered Meals Program	0	0		0 0	0	18.00
19.00	Homemaker Service	0	0		0 0	0	19.00
20.00	All Others (specify)	0	0		0 0	0	20.00
21.00	Total (sum of lines 1-20) (2)	0	0		0 0	0	21.00
22.00	Unit Cost Multiplier: column 18, line 1						22.00
	divided by the sum of column 18, line 21						
	minus column 18, line 1, rounded to 6						
	decimal places.						

(1) Column O, line 21 must agree with Wkst. A, column 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

(2) 00	dumis o through to, title 21 must agree with t	ine cerrespendir		INST: B, Ture I	11116 76.		
			OTHER GENERAL				
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES		Post Stepdown	Subtotal	
		ALLI ED HEALTH		of cols. 3A -	Adjustments	(col s. 16 ±	
		EDUCATI ON		15)		17)	
	Taran Sanara and American Sana	14. 00	15. 00	16. 00	17. 00	18. 00	
1.00	Administrative and General	0	0	79, 719		79, 719	1. 00
2.00	Skilled Nursing Care	0	0	309, 720		309, 720	2. 00
3.00	Physi cal Therapy	0	0	204, 595		204, 595	
4.00	Occupational Therapy	0	0	173, 968		173, 968	4. 00
5.00	Speech Pathology	0	0	31, 047	0	31, 047	5. 00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	11, 348	0	11, 348	7. 00
8.00	Suppl i es	0	0	12, 671	0	12, 671	8. 00
9.00	Drugs	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	10.00
11.00	Tel emedi ci ne	0	0	0	0	0	11.00
12.00	Home Dialysis Aide Services	0	0	0	0	0	12.00
13.00	Respi ratory Therapy	0	0	0	0	0	13.00
14.00	Private Duty Nursing	0	0	0	0	0	14.00
15. 00	Clinic	0	0	l 0	0	0	15. 00
16, 00	Health Promotion Activities	0	0	0	0	0	16.00
17. 00	Day Care Program	0	0	0	0	0	17. 00
18. 00	Home Delivered Meals Program	0	0	0	0	0	18. 00
19. 00	Homemaker Service	0	0	0	0	0	19. 00
20. 00	All Others (specify)	0	0		0	0	20. 00
21. 00	Total (sum of lines 1-20) (2)	0	0	823, 068	0	823, 068	
22. 00	Unit Cost Multiplier: column 18, line 1		Ĭ	020,000		020, 000	22. 00
22.00	divided by the sum of column 18, line 21						22.00
	minus column 18, line 1, rounded to 6						
	decimal places.						
	1400. ma. p. 4000.	(ı	1	I .		

(1) Column O, line 21 must agree with Wkst. A, column 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

	Cost Center Description	Allocated HHA	Total HHA	
		A&G (see Part	Costs	
		11)		
		19. 00	20.00	
1.00	Administrative and General			1. 00
2.00	Skilled Nursing Care	33, 215	342, 935	2. 00
3.00	Physi cal Therapy	21, 941	226, 536	3. 00
4.00	Occupational Therapy	18, 657	192, 625	4. 00
5.00	Speech Pathology	3, 330	34, 377	5. 00
6.00	Medical Social Services	0	0	6. 00
7.00	Home Health Aide	1, 217	12, 565	7. 00
8.00	Suppl i es	1, 359	14, 030	8. 00
9.00	Drugs	0	0	9. 00
10.00	DME	0	0	10. 00
11. 00	Tel emedi ci ne	0	0	11. 00
12.00	Home Dialysis Aide Services	0	0	12.00
13.00	Respiratory Therapy	0	0	13. 00
14.00	Private Duty Nursing	0	0	14. 00

Health Financial Systems	CONTINUING CARE AT SEAB	ROOK VILLAGE	In Lie	u of Form CMS-2540-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA CO	OST CENTERS	Provi der No.: 315469	Peri od: From 01/01/2021	Worksheet H-2 Part I

HHA CCN:

				Agency I	
	Cost Center Description	Allocated HHA	Total HHA		
		A&G (see Part	Costs		
		11)			
		19. 00	20.00		
15. 00	Clinic	0	0		15. 00
16.00	Health Promotion Activities	0	0		16. 00
17.00	Day Care Program	0	0		17. 00
18.00	Home Delivered Meals Program	0	0		18. 00
19. 00	Homemaker Service	0	0		19. 00
20.00	All Others (specify)	0	0		20. 00
21.00	Total (sum of lines 1-20) (2)	79, 719	823, 068		21. 00
22.00	Unit Cost Multiplier: column 18, line 1	0. 107243			22. 00
	divided by the sum of column 18, line 21				
	minus column 18, line 1, rounded to 6				
	decimal places.				
(1) Co	lumn O line 21 must agree with Wkst A colu	mn 7 line 70			

⁽¹⁾ Column O, line 21 must agree with Wkst. A, column 7, line 70.(2) Columns O through 18, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

Health Financial Systems CONTINUING CARE AT SEABROOK VILLAGE ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider No. Provi der No.: 315469

317093 HHA CCN:

In Lieu of Form CMS-2540-10
Worksheet H-2
Part II
Bate/Time Prepared:
9/7/2022 1: 37 pm
ealth PPS Peri od: From 01/01/2021 To 12/31/2021

Home Health

						Agency I	PPS	
		CAPITAL REI	LATED COS	TS		Agency 1		
	Cost Center Description	BLDGS &	MOVAB		EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FI XTURES	EQUI PM		BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE	FEET)	(GROSS		(ACCUM. COST)	
		1.00			SALARI ES)			
1. 00	Administrative and General	1.00	2.00	960	3.00	4A	4. 00 72, 775	1. 00
2. 00	Skilled Nursing Care	960		960	201, 130 137, 782			2. 00
3.00	Physical Therapy			0	91, 016			3. 00
4. 00	Occupational Therapy			0	77, 391			4. 00
5. 00	Speech Pathology			0	13, 811	0		5. 00
6. 00	Medical Social Services	0		0	13,011	0	0	6. 00
7. 00	Home Health Aide	0		0	5, 048	0		7. 00
8. 00	Supplies (see instructions)	0		0	3,040	0	11, 828	8. 00
9. 00	Drugs	0		0	Ö	0		9. 00
10. 00	DME	0		o	l d	0	l ol	10. 00
11. 00	Tel emedi ci ne	0		o	d	0	0	11. 00
12. 00	Home Dialysis Aide Services	0		0	C	0	0	12.00
13.00	Respiratory Therapy	0		o	C	0	0	13.00
14.00	Private Duty Nursing	0		o	C	0	0	14.00
15.00	Clinic	0		0	C	0	0	15.00
16.00	Health Promotion Activities	0		0	C	0	0	16.00
17.00	Day Care Program	0		0	C	0	0	17.00
18. 00	Home Delivered Meals Program	0		0	C	0	0	18.00
19. 00	Homemaker Service	0		0	C	0	0	19.00
20.00	All Others (specify)	0		0	C		0	20.00
21. 00	Total (sum of lines 1-20)	960		960	526, 178		766, 689	21.00
22. 00	Total cost to be allocated	12, 495		754	155, 728		54, 620	22.00
23. 00	Unit cost multiplier	13. 015625		785417	0. 295961		0. 071241	23. 00
	Cost Center Description	PLANT	LAUNDR		HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION,	LINEN SE		(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(TOTAL				(TOTAL DATE	
		(SQUARE FEET)	ENT DA	113)			(TOTAL PATI ENT DAYS)	
		5. 00	6. 00	1	7. 00	8. 00	9.00	
1. 00	Administrative and General	960		0	0			1. 00
2.00	Skilled Nursing Care	0	1	0	C	0	1	2. 00
3.00	Physical Therapy	0		0	C	0	0	3. 00
4.00	Occupational Therapy	0		o	C	0	0	4.00
5.00	Speech Pathology	0		0	C	0	0	5.00
6.00	Medical Social Services	0		0	C	0	0	6.00
7.00	Home Health Aide	0		0	C	0	0	7.00
8.00	Supplies (see instructions)	0		0	0	0	0	8.00
9.00	Drugs	0		0	0	0	0	9. 00
10. 00	DME	0		0	0	0	0	10. 00
11. 00	Tel emedi ci ne	0		0	C	0	0	11. 00
12. 00	Home Dialysis Aide Services	0		0	C	0	0	12. 00
13. 00	Respiratory Therapy	0		0	0	0	0	13. 00
14.00	Private Duty Nursing	0		0	0	0	0	14.00
15.00	Clinic	0		0	O	0	"	15.00
16.00	Health Promotion Activities	0		0		0	0	16.00
17. 00	Day Care Program	0		0	0	0	0	17.00
18. 00 19. 00	Home Delivered Meals Program Homemaker Service	0		0		0		18. 00 19. 00
20. 00	All Others (specify)	0	1	0		0		20. 00
21. 00	Total (sum of lines 1-20)	960		0		0		21. 00
22. 00	Total cost to be allocated	1, 759		0		0	0	22. 00
23. 00	Unit cost multiplier	1. 832292		000000	0. 000000	0. 000000	0. 000000	23. 00
20.00	Cost Center Description	CENTRAL	PHARMA		MEDI CAL	SOCIAL SERVICE		20.00
	out contain baser per an	SERVICES &	(TOTAL	-	RECORDS &	0001712 021111 02	ALLI ED HEALTH	
		SUPPLY	ENT DA		LI BRARY	(TOTAL PATI	EDUCATI ON	
		(TOTAL PATI			(TOTAL PATI	ENT DAYS)	(TOTAL PATI	
		ENT DAYS)			ENT DAYS)		ENT DAYS)	
	To the second se	10.00	11. 0		12. 00	13. 00	14. 00	
1.00	Administrative and General	0		0	C	_		1. 00
2.00	Skilled Nursing Care	0		0	C	0	ı "	2. 00
3.00	Physical Therapy	0		0	0	0	0	3. 00
4.00	Occupational Therapy	0		0	0	0	0	4. 00
5.00	Speech Pathology	0		0		0	0	5. 00
6.00	Medical Social Services			0		0	0	6. 00
7.00	Home Health Aide			Ö			0	7.00
8. 00 9. 00	Supplies (see instructions) Drugs			0				8. 00 9. 00
10.00				0	_			
	10		I .	્ <u></u>			·	

 BROOK VILLAGE
 In Lieu of Form CMS-2540-10

 Provider No.: 315469
 Period: From 01/01/2021
 Worksheet H-2 Part II

 HHA CCN:
 317093
 To 12/31/2021
 Date/Time Prepared: Date/Time Health Financial Systems CONTINUING CARE AT SEABROOK VILLAGE ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider No. BASIS

			TITIA CON.	317073	10 12/31/2021	9/7/2022 1: 37	
					Home Health Agency I	PPS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG AND	
		SERVICES &	(TOTAL PATI	RECORDS &		ALLI ED HEALTH	
		SUPPLY	ENT DAYS)	LIBRARY	(TOTAL PATI	EDUCATI ON	
		(TOTAL PATI		(TOTAL PATI	ENT DAYS)	(TOTAL PATI	
		ENT DAYS) 10.00	11.00	12.00	13. 00	ENT DAYS) 14.00	
11. 00	Tel emedi ci ne	10.00	11.00		0 0		11. 00
12. 00	Home Dialysis Aide Services		0	l .	0 0		12. 00
13. 00	Respiratory Therapy		0		0 0	0	13. 00
14. 00	Private Duty Nursing		0		0 0		14. 00
15. 00	Clinic	0	0)	0 0	0	15. 00
16.00	Health Promotion Activities	0	0)	0 0	0	16. 00
17.00	Day Care Program	o	0)	0 0	0	17. 00
18.00	Home Delivered Meals Program	0	0		0 0	0	18. 00
19. 00	Homemaker Service	0	0)	0	0	19. 00
20. 00	All Others (specify)	0	0	1	0	0	20. 00
21. 00	Total (sum of lines 1-20)	0	0	1	0	0	21. 00
22. 00	Total cost to be allocated	0 000000	0		0 0	0	22. 00
23. 00	Unit cost multiplier	O. 000000 OTHER GENERAL	0. 000000	0.00000	0. 000000	0. 000000	23. 00
		SERVI CE					
	Cost Center Description	ACTI VI TI ES					
		(PATIENT DA					
		YS)					
		15. 00					
1.00	Administrative and General	0					1. 00
2.00	Skilled Nursing Care	0					2.00
3. 00 4. 00	Physical Therapy Occupational Therapy	0					3. 00 4. 00
5. 00	Speech Pathology	0					5. 00
6. 00	Medical Social Services						6. 00
7. 00	Home Heal th Ai de						7. 00
8. 00	Supplies (see instructions)						8. 00
9.00	Drugs	0					9. 00
10.00	DME	o					10. 00
11. 00	Tel emedi ci ne	0					11. 00
12.00	Home Dialysis Aide Services	0					12.00
13. 00	Respiratory Therapy	0					13. 00
14.00	Private Duty Nursing	0					14. 00
15. 00 16. 00	Clinic	0					15. 00 16. 00
17. 00	Health Promotion Activities Day Care Program	0					17. 00
18. 00	Home Delivered Meals Program						18.00
19. 00	Homemaker Service						19. 00
20. 00	All Others (specify)						20. 00
21. 00	Total (sum of lines 1-20)	0					21. 00
22. 00	Total cost to be allocated	0					22. 00
23. 00	Unit cost multiplier	0. 000000					23. 00

Heal th	Financial Systems	CONTINUING CARE AT	SEABROOK VIIIA	AGF	In lie	u of Form CMS-2	2540-10
	TIONMENT OF PATIENT SERVICE COSTS			No.: 315469 317093	Peri od: From 01/01/2021 To 12/31/2021	Worksheet H-3 Parts I-II Date/Time Pre	pared:
			Ti tl	e XVIII	Home Health	9/7/2022 1: 37 PPS	pm
	Cost Contor Doscription	From, Wkst.	Facility Costs	Shared	Agency I Total HHA	Total Visits	
	Cost Center Description	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols. 1		
		col. 20, line	7	Costs (from			
			1.00	Part II)			
	PART I - COMPUTATION OF THE AGGREGATE PR	OCDAM COST	1.00	2.00	3. 00	4. 00	
	Cost Per Visit Computation	OGRAW COST					
1.00	Skilled Nursing Care	2. 00	342, 935		342, 935	1, 287	1. 00
2.00	Physi cal Therapy	3. 00			0 226, 536	978	2. 00
3.00	Occupational Therapy	4. 00			0 192, 625	756	3. 00
4.00	Speech Pathology	5. 00			0 34, 377	113	4. 00
5. 00 6. 00	Medical Social Services Home Health Aide	6. 00 7. 00			0 12, 565	2 236	5. 00 6. 00
7. 00	Total (sum of lines 1-6)	7.00	809, 038		0 809, 038		7. 00
7.00	Total (sum of fines 1 o)		007,030		Program Vi si ts		7.00
					Par	t B	
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to		
					Deductibles &	Deducti bl es	
		0	1.00	2.00	Coi nsurance 3. 00	4. 00	
	Patient Services by CBSA		1.00	2.00	0.00	1. 00	
8.00	Skilled Nursing Care		35154		0 1		8. 00
8.01	Skilled Nursing Care		50012		0 785		8. 01
8. 02	Skilled Nursing Care		50020		0 5		8. 02
9.00	Physical Therapy		35154		0 0		9. 00
9. 01 9. 02	Physical Therapy		50012		0 640		9. 01 9. 02
10.00	Physical Therapy Occupational Therapy		50020 35154		0 3		9. 02 10. 00
10. 00	Occupational Therapy		50012		0 490		10.00
10. 02	Occupational Therapy		50020		0 3		10. 02
11. 00	Speech Pathology		35154		0 0		11. 00
11. 01	Speech Pathology		50012		0 74		11. 01
11. 02	1 1		50020		0 1		11. 02
12.00	Medical Social Services		35154		0		12. 00
12. 01	Medical Social Services		50012		0 2		12. 01
12. 02	Medical Social Services		50020		0 0		12. 02
13. 00 13. 01	Home Health Aide Home Health Aide		35154 50012		0 0 170		13. 00 13. 01
13. 01	Home Heal th Aide		50012		0 0		13. 01
	Total (sum of lines 8-13)		00020		0 2, 174		14. 00
	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols. 1		
		20, line	H-2, Part I)	Costs (from	+ 2)	Record)	
		0	1 00	Part II) 2.00	2 00	4.00	
			1.00	2.00	3. 00	4. 00	
	Supplies and Drugs Cost Computations				0 11 000	0	
15. 00	Supplies and Drugs Cost Computations Cost of Medical Supplies	8. 00	14, 030		0 14, 030	0	15.00
		8. 00 9. 00			0 14, 030	0	
	Cost of Medical Supplies		From Wkst. C,	Cost to Charç	0 0 ge Total HHA	0 HHA Shared	
	Cost of Medical Supplies Cost of Drugs		From Wkst. C, Part I, col.		0 0 ge Total HHA Charge (from	0 HHA Shared Ancillary	
	Cost of Medical Supplies Cost of Drugs		From Wkst. C,	Cost to Charç	ge Total HHA Charge (from provider	0 HHA Shared Ancillary Costs (col. 1	
	Cost of Medical Supplies Cost of Drugs		From Wkst. C, Part I, col. 3, line	Cost to Charç Ratio	o 0 ge Total HHA Charge (from provider records)	0 HHA Shared Ancillary Costs (col. 1 x col. 2)	
	Cost of Medical Supplies Cost of Drugs Cost Center Description	9.00	From Wkst. C, Part I, col. 3, line	Cost to Charç Ratio 1.00	0 0 ge Total HHA Charge (from provider records) 2.00	HHA Shared Ancillary Costs (col. 1 x col. 2) 3.00	
16. 00	Cost of Medical Supplies Cost of Drugs	9.00	From Wkst. C, Part I, col. 3, line	Cost to Charg Ratio 1.00 ED NURSING FA	o O O ge Total HHA Charge (from provi der records) 2.00 CCILITY DEPARTMEN	HHA Shared Ancillary Costs (col. 1 x col. 2) 3.00	16. 00
16. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART II - APPORTIONMENT OF COST OF HHA S	9.00	From Wkst. C, Part I, col. 3, line 0 BY SHARED SKILL	Cost to Charg Ratio 1.00 ED NURSING FA 0.56454	o O O O O O O O O O O O O O O O O O O O	HHA Shared Ancillary Costs (col. 1 x col. 2) 3.00	1. 00
1.00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART II - APPORTIONMENT OF COST OF HHA S Physical Therapy Occupational Therapy Speech Pathology	9.00	0 From Wkst. C, Part I, col. 3, Iine 0 SY SHARED SKILL 44.00 45.00 46.00	Cost to Charg Ratio 1.00 ED NURSING FA 0.56454 0.58072 0.53270	O O O O O O O O O O O O O O O O O O O	HHA Shared Ancillary Costs (col. 1 x col. 2) 3.00	1. 00
1. 00 2. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART II - APPORTIONMENT OF COST OF HHA S Physical Therapy Occupational Therapy	9.00	From Wkst. C, Part I, col. 3, line 0 SY SHARED SKILL 44.00 45.00	Cost to Charg Ratio 1.00 ED NURSING FA 0.56454 0.58072 0.53270 48.88884	O O O ge Total HHA Charge (from provider records) 2.00 CCILITY DEPARTMEN 13 O 28 O 69 O	0 HHA Shared Ancillary Costs (col. 1 x col. 2) 3.00 JTS 0 0	1. 00 2. 00 3. 00 4. 00

PORTI O	NMENT OF PATIENT SERVICE COSTS		Provi der	No.: 315469 317093	Peri od: From 01/01/2021 To 12/31/2021	Worksheet H-3 Parts I-II Date/Time Pre 9/7/2022 1:37	epare
			Ti t	le XVIII	Home Health Agency I	PPS	
				Program Visi		Cost of Services	
				Р	art B	00. 1. 000	
	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Not Subject Deductibles Coinsurance	& Deductibles &	Part A	
		5.00	6. 00	7.00	8. 00	9. 00	
PA	ART I - COMPUTATION OF THE AGGREGATE	<u> </u>			5. 55		
Co	ost Per Visit Computation						
00 SI	killed Nursing Care	266. 46		0 7'	91	C	1.
00 Pt	nysi cal Therapy	231. 63		0 6	43	C	2.
00 00	ccupational Therapy	254. 79		0 4	93	C	3.
00 S	peech Pathology	304. 22		0	75	C	4.
OO Me	edi cal Soci al Servi ces	0.00		0	2	C	5.
00 H	ome Health Aide	53. 24		0 1	70	C	6.
00 To	otal (sum of lines 1-6)			0 2, 1	74	C	7.
•	Cost Center Description						
		5. 00	6. 00	7. 00	8. 00	9. 00	
	itient Services by CBSA			1			4 .
1	killed Nursing Care						8.
	killed Nursing Care	1					8.
	killed Nursing Care	1					8
	nysi cal Therapy						9.
	nysi cal Therapy						9.
	nysi cal Therapy						9.
00 0	ccupational Therapy						10.
01 00	ccupational Therapy						10.
02 0	ccupational Therapy						10
00 St	peech Pathology						11.
01 S	peech Pathology						11
02 S	peech Pathology						11.
00 Me	edical Social Services						12
01 Me	edical Social Services						12
02 Me	edical Social Services	1					12
00 H	ome Health Aide						13
01 H	ome Health Aide	i i					13
	ome Health Aide	1					13
00 To	otal (sum of lines 8-13)						14
			Pro	gram Covered C	Charges	Cost of Services	
					art B		
	Cost Center Description	Ratio (col. 3	Part A	Not Subject	to Subject to	Part A	
		÷ col. 4)		Deducti bl es	& Deductibles &		
				Coi nsurance			
-		5.00	6. 00	7. 00	8. 00	9. 00	-
	upplies and Drugs Cost Computations ost of Medical Supplies	0. 000000		1			15
	ost of Medical Supplies	0. 000000			0 0		16
00 00	Cost Center Description	0.000000	Transfor	to Part I as	U U		10.
	oost deliter bescription			cated			
PΔ	RT II - APPORTIONMENT OF COST OF HHA	SERVICES FURNISHED BY		.00 LED NURSING FA	ACILITY DEPARTMEN	ITS	
	nysical Therapy		ol. 2, line		IO. ELTT DELTARTIMEN		1
1	ccupational Therapy		ol. 2, line				2
o loa		ĮC	,		1		
	peech Pathology	h	ol 2 line	4 00			2
0 S	peech Pathology ost of Medical Supplies		ol. 2, line ol. 2, line				3.

		ONTINUING CARE AT SE				u of Form CMS-	
APPORT	IONMENT OF PATIENT SERVICE COSTS		HHA CCN:	No.: 315469 317093	Peri od: From 01/01/2021 To 12/31/2021	Worksheet H-3 Parts I-II Date/Time Pre 9/7/2022 1:37	epared:
			Ti tl	e XVIII	Home Health Agency I	PPS	, piii
		Cost of Se	rvi ces		rigency :		
		Part					
	Cost Center Description	Not Subject to Deductibles & De	Subject to eductibles &	Total Progra Cost (sum o			
		Coi nsurance (Coi nsurance 11.00	col s. 9-10) 12.00			
	PART I - COMPUTATION OF THE AGGREGATE PROG		11.00	12.00			
00	Cost Per Visit Computation Skilled Nursing Care	210, 770		210.7	70		1 1 0
1. 00 2. 00	Physical Therapy	210, 770 148, 938		210, 7 148, 9			1.0
. 00	Occupational Therapy	125, 611		125, 6			3.0
1. 00	Speech Pathology	22, 817		22, 8			4. 0
. 00	Medical Social Services	0		,, -	0		5. 0
5. 00	Home Heal th Aide	9, 051		9, 0	51		6.0
7. 00	Total (sum of lines 1-6)	517, 187		517, 18	87		7. 0
	Cost Center Description						
	Tarana arang ar	10.00	11. 00	12. 00			
	Patient Services by CBSA			Γ			٠,
. 00 . 01	Skilled Nursing Care Skilled Nursing Care						8.0
. 02	Skilled Nursing Care						8.0
0. 00	Physical Therapy						9.0
. 01	Physical Therapy						9.0
. 02	Physical Therapy						9.0
0.00	Occupational Therapy						10.0
0. 01	Occupational Therapy						10. C
0. 02	Occupational Therapy						10.0
1.00	Speech Pathology						11.0
1. 01	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						11.0
	Speech Pathology						11. C
2. 00	Medical Social Services						12.0
2. 01	Medical Social Services						12.0
2. 02	Medical Social Services Home Health Aide						12. 0 13. 0
3. 00	Home Health Aide						13. 0
	Home Health Aide						13. 0
	Total (sum of lines 8-13)						14. 0
55		Cost of Se	rvi ces				1 0
		Part	D				
	Cost Center Description		Subject to				
	JOST JOHN DESCRIPTION	Deductibles & De					
			Coi nsurance				
		10.00	11. 00				
	Supplies and Drugs Cost Computations						
	Cost of Medical Supplies						15. 0
6.00	Cost of Drugs	0	0				16.0

	Financial Systems CONTINUING CARE AT SEAF				u of Form CMS-2	
CALCULATION OF SNF-BASED HHA REIMBURSEMENT SETTLEMENT Pr			No.: 315469	Peri od: From 01/01/2021	Worksheet H-4 Parts I-II	
		HHA CCN:	317093		Date/Time Pre 9/7/2022 1:37	
		Ti tl	e XVIII	Home Health	PPS	
				Agency I		
			D+ A		t B	
			Part A	Not Subject to Deductibles &		
				Coi nsurance	Coi nsurance	
		1, 00	2. 00	3. 00		
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGE		2.00	3.00	
	Reasonable Cost of Part A & Part B Services	7.11.1 01.11.11.02	<u> </u>			1
1.00	Reasonable cost of services (see instructions)			0 0	0	1.00
2.00	Total charges			0 0	0	2. 00
	Customary Charges					1
3.00	Amount actually collected from patients liable for payment for	servi ces		0 0	0	3.00
	on a charge basis (from your records)					
4.00	Amount that would have been realized from patients liable for p			0 0	0	4. 00
	for services on a charge basis had such payment been made in ac					
	with 42 CFR 413.13(b)					
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.0000		0. 000000	1	
6. 00 7. 00	,			0 0	0	
7.00	Excess of total customary charges over total reasonable cost (conly if line 6 exceeds line 1)	olibrete		0	0	7. 00
8. 00	Excess of reasonable cost over customary charges (complete only		0 0	0	8. 00	
0.00	1 exceeds line 6)			O	0.00	
9. 00	· ·				0	9. 00
			•	Part A	Part B	
				Servi ces	Servi ces	
	DART III GOMBUTATION OF ONE DAGED HIM DELMBURGEMENT OFFICEMENT			1. 00	2. 00	
10.00	PART II - COMPUTATION OF SNF-BASED HHA REIMBURSEMENT SETTLEMENT				0	10.00
10. 00 11. 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0	0 544, 705	
12. 00	Total PPS Reimbursement - Full Episodes without outliers			0	48, 068	1
13. 00	Total PPS Reimbursement - LUPA Episodes			0	11, 978	
14. 00	Total PPS Reimbursement - PEP Epi sodes			0	0	1
15. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	11, 677	
16. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	1
17. 00	Total Other Payments			0	0	1
18.00	DME Payments			0	0	18. 00
19.00	Oxygen Payments			0	0	19. 00
20.00	Prosthetic and Orthotic Payments		0	0	20.00	
21. 00	Part B deductibles billed to Medicare patients (exclude coinsur	ance)			0	
22. 00	Subtotal (sum of lines 10 thru 20 minus line 21)			0	616, 428	1
23. 00	Excess reasonable cost (from line 8)			0	0	
24. 00	Subtotal (line 22 minus line 23)			0	616, 428	
25. 00	Coinsurance billed to program patients (from your records)			_	(14, 420	
26. 00	Net cost (line 24 minus line 25)			0	616, 428 0	1
27. 00 28. 00	Allowable bad debts (from your records) Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	0	
29. 00				0	616, 428	
					010,420	27.00
30 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIEY)	,		0	n	30 00
30. 00 30. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Demonstration payment adjustment amount before sequestration	,		0	0	

30.75

31. 00

32.00

33. 00 34. 00 0 0

35. 00

0 30. 99

616, 428 616, 428

30. 99

31.00

30.75 | Sequestration for non-claims based amounts (see instructions)

33.00 Tentative settlement (for contractor use only)
34.00 Balance due provider/program (see instructions)
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,

Sequestration amount (see instructions)
Subtotal (see instructions)

32.00 Interim payments (see instructions)

section 115.2

ANALYSIS OF PAYMENTS TO SNF-BASED HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provi der No.: 315469

Period: Worksheet H-5 From 01/01/2021

HHA CCN: 317093 To 12/31/2021 Date/

Home Health

Date/Ti me Prepared: 9/7/2022 1:37 pm PPS

Agency I Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3. 00 1.00 Total interim payments paid to provider 616, 428 1.00 2.00 Interim payments payable on individual bills, either 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 0 0 3. 01 0 3.02 0 3.02 0 3 03 3.03 0 3.04 0 3.04 3.05 0 0 3.05 Provider to Program 3 50 0 3.50 0 0 3.51 0 3.51 3.52 0 0 3. 52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98)) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 616, 428 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 0 0 5.01 0 0 5.02 5.02 5.03 5.03 0 0 Provider to Program 5.50 0 0 5.50 5.51 0 0 5.51 0 5 52 0 5 52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (see instructions) SETTLEMENT TO PROVIDER 6.01 0 0 6.01 SETTLEMENT TO PROGRAM 6.02 0 Λ 6.02 7.00 Total Medicare program liability (see instructions) 616, 428 7.00 Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor Novi tas Solutions 12001 8.00