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 Provi der CCN: 315422 Period: Worksheet S From 01/01/2021 Parts I, II & III Peri od: COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared:

					5/26/202	2 4:3	1 pm د
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically prepared cost re	port		Date: 5/26/2	2022 Ti r	ne: 4	4: 31 pm
use only	2. [] Manually prepared cost report						
	3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report						
	3.01 [] No Medicare Utilization. Enter	"Y" for yes or le	ave blank for no.				
Contractor	4.[1]Cost Report Status	6. Contractor No.					
use only	(2) Settled without audit	7.[N] First Cost Report for this Provider CCN					
		8.[N] Last Cost Report for this Provider CCN					
		9. NPR Date:	·				
	(4) Reopened	10.[0] f line	4, column 1 is "4":	 Enter number	of times re	eopen:	ed
	(5) Amended	11.Contractor Ve	ndor Code	4			
	5. Date Received:	12.[F] Medicare	Utilization. Enter	 "F" for full,	"L" for I	OW, O	or "N"
	I .						

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOUSE OF THE GOOD SHEPHERD (315422) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Sus	an Lanza	Y	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	Susan Lanza			2
3	Signatory Title	CHIEF EXECUTIVE OFFICER			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	15, 485	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 FOHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	15, 485	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.

Heal th	Financial Systems	HOUSE OF	THE GOOD S	HEPHERD		l r	n Lieu	ı of Form	n CMS-:	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACIL					Period: From 01/01/		Workshe Part I		
COMPLE	EX INDENTIFICATION DATA					To 12/31/		Date/Ti		
	1. 00		2. 00		3. 00			5/26/20	22 4.3) DIII
1. 00	Skilled Nursing Facility and Skilled Nursing Street: 798 WILLOW GROVE STREET	Facility PO Box:	Complex Ac	ddress:						1.00
2. 00	Ci ty: HACKETTSTOWN	State: N.	J	Zi p Code	: 07840					2.00
3.00	County: WARREN	CBSA Code		Urban/Ru	ral : U					3. 00 3. 01
3. 01		CBSA Code		ent Name	Provi der	Date	Payme	ent Syste	em (P,	3.01
					CCN	Certi fi ed	V	0, or N	XIX	
			1	. 00	2.00	3. 00	4.00		6. 00	
4. 00	SNF and SNF-Based Component Identification:		HOUSE OF TH	JE COOD	315422	08/25/1997	N	P	N	4.00
4.00	SIVE		SHEPHERD	TE GOOD	313422	00/23/199/	l IN		IN	4.00
5.00	Nursing Facility									5.00
6. 00 7. 00	ICF/IID SNF-Based HHA									6. 00 7. 00
8.00	SNF-Based RHC									8.00
9. 00 10. 00	SNF-Based FQHC SNF-Based CMHC									9. 00 10. 00
11. 00	SNF-Based OLTC									11. 00
	SNF-Based HOSPICE SNF-Based CORF									12. 00 13. 00
13.00	JNI -baseu CONI					From:		To:		13.00
14 00	Cost Reporting Period (mm/dd/yyyy)					1.00		2. 0 12/31/		14. 00
	Type of Control (See Instructions)					01/01/2		CORPORAT		15. 00
								Y/N 1. 0		-
	Type of Freestanding Skilled Nursing Facilit	у						1.0	<u> </u>	
16. 00	00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16 section 483.5?									16. 00
17. 00	00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 1								17. 00	
18 00	42 CFR section 483.5? Are there any costs included in Worksheet A	that resu	lted from t	ransactio	one with relat	ad		N		18. 00
10.00	organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.								18.00	
10.00	Miscellaneous Cost Reporting Information If this is a low Medicare utilization cost r	oport in	dicata with	. o "V" +	for you or "N	" for no		N		19. 00
	If line 19 is yes, does this cost report mee						~e	N N		19.00
	utilization cost report, indicate with a "Y"				the method in	dicated on	Lino	20 2	າ	
20. 00	Depreciation - Enter the amount of depreciat Straight Line	.i oii Tepoi	teu in tilis	S SINF TUI	the method in	idi cated on	LITTE			20.00
	Declining Balance								C	21.00
	Sum of the Year's Digits Sum of line 20 through 22							1. 0) 12. 937	22.00 23.00
24. 00	If depreciation is funded, enter the balance							., -	, , , , , ,	24.00
	Were there any disposal of capital assets du Was accelerated depreciation claimed on any					nortina ner	ri od?	Y N		25. 00 26. 00
	(Y/N)									
27. 00	Did you cease to participate in the Medicare applies? (Y/N)	program	at end of t	the period	d to which thi	s cost repo	ort	N		27. 00
28. 00	Was there a substantial decrease in health i	nsurance	proporti on	of allowa	able cost from	pri or cost	t	N		28. 00
	reports? (Y/N)						Part	A Part B	Other	
							1. 00	2.00	3. 00	
	If this facility contains a public or non-pu the lower of the costs or charges enter "Y"								n of	
	exemption.	TOT CACIT	component a	and type (or service tild	it quairite	3 101			
29. 00 30. 00	Skilled Nursing Facility Nursing Facility						N	N	N	29. 00 30. 00
31. 00	ICF/IID								IN	31.00
32.00	SNF-Based HHA						N	N		32.00
33. 00 34. 00	SNF-Based RHC SNF-Based FOHC							N		33. 00 34. 00
35.00	SNF-Based CMHC							N		35. 00
36. 00	SNF-Based OLTC					Y/N				36.00
						1.00		2. 0	0	
37. 00	Is the skilled nursing facility located in a regardless of the level of care given for Ti				ovider as a SN	F N				37. 00
38. 00	Are you legally-required to carry malpractic	e insuran	ce? (Y/N)	, ,		Y				38. 00
39. 00	Is the malpractice a "claims-made" or "occur "claims-made" enter 1. If the policy is "occ			ne policy	is	1				39. 00
	Graniis-made enter i. II the portey is occ	arrence ,	circi Z.		Premi ums	Paid Los	ses S			
41 00	List malpractice premiums and paid losses:				1. 00 131, 273	2.00		3.00)	41.00
4 1.00	List marpractice premiums and pard 105565:				131,2/3	ı	- 1	U		1 41.00

Heal th	h Financial Systems HOUSE OF THE GOOD SHEPHERD In Lieu				u of Form CMS-2	2540-10		
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31	15422 Peri od:	Worksheet S-2			
COMPLE	EX INDENTIFICATION DATA			From 01/01/2021	Part I			
				To 12/31/2021	Date/Time Pre			
					5/26/2022 4: 3	1 pm		
					Y/N			
		1.00						
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrat	ive 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 def	ined in CMS Pub. 15-1. Ch	apter 10?		l N	43.00		
	If line 43 is yes, enter the home office			dress of the home		44.00		
	office on lines 45, 46 and 47.							
	1.00	2.00		3. 00	l.			
	If this facility is part of a chain or		e and address of		e Lines			
	bel ow.	gam zatron, onto the man						
45. 00	Name:	Contractor's Name:	Co	ontractor's Number:		45.00		
	Street:	PO Box:		ontractor 3 Number.		46.00		
			١,,,	0.1		46.00		
47.00	7. 00 City: Zip Code: Zi							

Heal th Fi	nancial Systems	HOUSE OF THE GOOD SHEPHER	RD	In Lie	eu of Form CMS-	2540-10
SKI LLED N	NURSING FACILITY AND SKILLED NURSING FACILI REIMBURSEMENT QUESTIONNAIRE		der No.: 315422	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre	epared:
				Y/N	5/26/2022 4: 3 Date	ST PIII
Ger	neral Instruction: For all column 1 respons	ses enter in column 1 "Y	" for Yes or "N	1.00	2.00	
res Con	sponses the format will be (mm/dd/yyyy) mpleted by All Skilled Nursing Facilites ovider Organization and Operation	ses errei III dei ami I,	101 103 01 1			
1.00 Ha	us the provider changed ownership immediate porting period? If column 1 is "Y", enter structions)	ly prior to the beginning the date of the change in	of the cost column 2. (see	N		1.00
			1. 00	Date 2.00	V/I 3. 00	
со	s the provider terminated participation in Dumn 1 is yes, enter in column 2 the date "V" for voluntary or "I" for involuntary.		N			2. 00
3.00 Is color of of	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N					3.00
				Type	Date	
Fir	nancial Data and Reports		1.00	2. 00	3. 00	
4. 00 Co Acc Cor	olumn 1: Were the financial statements prep countant? (Y/N) Column 2: If yes, enter "A ompiled, or "R" for Reviewed. Submit comple vailable in column 3. (see instructions) If	" for Audited, "C" for te copy or enter date	С	A	07/31/2022	4.00
5.00 Are	re the cost report total expenses and total lose on the filed financial statements? If econciliation.	revenues different from	Y			5. 00
				Y/N 1.00	Legal Oper.	
	proved Educational Activities				2. 00	
	olumn 1: Were costs claimed for Nursing Sch egal operator of the program? (Y/N)	ool? (Y/N) Column 2: Is	the provider th	ne N	N	6. 00
7. 00 We 8. 00 We	ere costs claimed for Allied Health Program ere approvals and/or renewals obtained duri chool and/or Allied Health Program? (Y/N) s	ng the cost reporting per		y N N		7. 00 8. 00
	d Debts				Y/N 1.00	
9.00 Is 10.00 If	s the provider seeking reimbursement for bafiline 9 is "Y", did the provider's bad deberiod? If "Y", submit copy.	. ,		cost reporting	Y N	9. 00 10. 00
11.00 If	fline 9 is "Y", are patient deductibles and Complement	d/or coinsurance waived?	If "Y", see ins	structions.	N	11.00
12. 00 Ha	ve total beds available changed from prior	cost reporting period? I		tructions. Part A	N Part B	12.00
		Description	Y/N	Date	Y/N	
DC	&R Data	0	1.00	2. 00	3. 00	
13.00 Was	is the cost report prepared using the PS&R ily? If either col. 1 or 3 is "Y", enter be paid through date of the PS&R used to repare this cost report in cols. 2 and (see Instructions.)		Y	05/06/2022	Y	13.00
14.00 Was for all	is the cost report prepared using the PS&R or total and the provider's records for location? If either col. 1 or 3 is "Y" ater the paid through date of the PS&R used prepare this cost report in columns 2 and		N		N	14.00
15.00 If made has PS	Fline 13 or 14 is "Y", were adjustments de to PS&R data for additional claims that live been billed but are not included on the S&R used to file this cost report? If "Y", be Instructions.		N		N	15. 00
16.00 If	Fline 13 or 14 is "Y", then were Ijustments made to PS&R data for prrections of other PS&R Report		N		N	16.00
co	formation? If yes, see instructions.					
17.00 If adj	oformation? If yes, see instructions. Iline 13 or 14 is "Y", then were Ijustments made to PS&R data for Other? Secribe the other adjustments:		N		N	17. 00

Heal th	Financial Systems HOU	USE OF THE GO	OOD SHEPHERD		In Lie	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/26/2022 4:3	pared:	
			1.	00	2. (00	
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title/p	position D	DEANDRA		FALLON		19. 00
	held by the cost report preparer in columns 1, respectively.	2, and 3,					
20.00	Enter the employer/company name of the cost rep	port E	BAKER TILLY US	, LLP			20.00
	preparer.						
	Enter the telephone number and email address of		70-820-0301		DEANDRA. FALLON	BAKERTI LLY. CO	21.00
	report preparer in columns 1 and 2, respectivel	ly.			М		

Health Financial Systems	HOUSE OF THE GOOD	SHEPHERD	In Lieu	u of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED	NURSING FACILITY HEALTH CARE	Provi der No.: 315422		Worksheet S-2
COMPLEX REIMBURSEMENT QUESTIONNAIRE			From 01/01/2021	Part II Nate/Time Prepared:

COMPLEX REIMBURSEMENT QUESTIONNAIRE			rom 01/01/2021 To 12/31/2021	
	Part B Date 4.00			
PS&R Data				
13.00 Was the cost report prepared using the only? If either col. 1 or 3 is "Y", ent the paid through date of the PS&R used prepare this cost report in cols. 2 and 4. (see Instructions.)	er to			13.00
14.00 Was the cost report prepared using the for total and the provider's records fo allocation? If either col. 1 or 3 is "Y enter the paid through date of the PS&R to prepare this cost report in columns 4.	or ''' ! used			14.00
15.00 If line 13 or 14 is "Y", were adjustmen made to PS&R data for additional claims have been billed but are not included o PS&R used to file this cost report? If see Instructions.	that on the			15. 00
16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.				16. 00
17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other Describe the other adjustments:				17.00
18.00 Was the cost report prepared only using provider's records? If "Y" see Instruct				18.00
		3.00	-	
Cost Report Preparer Contact Information				
19.00 Enter the first name, last name and the held by the cost report preparer in col respectively.	•	SENI OR MANAGER		19.00
20.00 Enter the employer/company name of the preparer.	cost report			20.00
21.00 Enter the telephone number and email ad report preparer in columns 1 and 2, res				21.00

Health Financial Systems HOUSE OF THE GO
SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared: 5/26/2022 4: 31 pm Provi der No.: 315422

				12/31/2021	5/26/2022 4: 3	
			I npa	atient Days/Vis	its	
Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
1.00 SKILLED NURSING FACILITY 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST 5.00 Other Long Term Care	62 0 0	22, 630 0 0	0	802	4, 855 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
6.00 SNF-Based CMHC 7.00 HOSPICE 8.00 Total (Sum of lines 1-7)	0 62	0 22, 630	0	0 802	0 4, 855	6. 00 7. 00 8. 00
	Inpatient D			Di scharges	·	
Component	0ther	Total	Title V	Title XVIII	Title XIX	
	6. 00	7. 00	8. 00	9. 00	10.00	
1.00 SKILLED NURSING FACILITY 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST 5.00 Other Long Term Care 6.00 SNF-Based CMHC	2, 354 0 0 0 0	8, 011 0 0 0 0	0	40	2 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 HOSPICE		٥	0	٥	0	7. 00
8.00 Total (Sum of lines 1-7)	2, 354	8, 011	0	40	2	8. 00
er de Tratar (dam er Trinde 1 7)	Di scha		Aver	age Length of		0.00
		J				
Component	Other	Total	Title V	Title XVIII	Title XIX	
	11. 00	12. 00	13.00	14. 00	15. 00	
1.00 SKILLED NURSING FACILITY 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST 5.00 Other Long Term Care 6.00 SNF-Based CMHC	47 0 0	89 0 0	0. 00 0. 00	20. 05	2, 427. 50 0. 00 0. 00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 HOSPI CE	o	0	0. 00	0.00	0.00	7. 00
8.00 Total (Sum of lines 1-7)	47	89	0. 00	20. 05	2, 427. 50	8. 00
	Average Length of Stay		Admis	si ons		
Component	Total	Title V	Title XVIII	Title XIX	Other	
· ·	16. 00	17. 00	18. 00	19. 00	20.00	
1.00 SKILLED NURSING FACILITY 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST	90. 01 0. 00 0. 00	0	40	2 0 0	35 0 0	1. 00 2. 00 3. 00 4. 00
5.00 Other Long Term Care 6.00 SNF-Based CMHC	0.00				0	5. 00 6. 00
7.00 HOSPICE 8.00 Total (Sum of lines 1-7)	0. 00 90. 01	0	0 40	0	0 35	7. 00 8. 00
6.00 Total (Suill Of Titles 1-7)	Admi ssi ons	Full Time E			33	8.00
Component	Total	Employees on Payroll	Nonpai d Workers			
	21. 00	22. 00	23. 00			
1.00 SKILLED NURSING FACILITY 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST 5.00 Other Long Term Care 6.00 SNF-Based CMHC 7.00 HOSPICE	77 0 0 0	88. 92 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8.00 Total (Sum of lines 1-7)	77	88. 92	0. 00			8. 00

				To	12/31/2021	Date/Time Pre	
		Amount	Reclass. of	Adj usted	Paid Hours	5/26/2022 4: 3 Average	ı pili
		Reported	Salaries from	Sal ari es	Related to	Hourly Wage	
		Reported	Worksheet A-6	(col . 1 ±	Salary in	(col. 3 ÷	
			WOLKSHEET A-0	col . 2)	col. 3	col . 4)	
		1. 00	2.00	3.00	4, 00	5. 00	
	PART II - DIRECT SALARIES	1. 00	2.00	0.00	1. 00	0.00	
	SALARI ES						
1.00	Total salaries (See Instructions)	4, 536, 710	0	4, 536, 710	184, 960. 00	24. 53	1.00
2.00	Physician salaries-Part A	0	o	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	o	0	0. 00	0.00	3.00
4.00	Home office personnel	0	o	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	o	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	4, 536, 710	o	4, 536, 710	184, 960. 00	24. 53	6.00
7.00	Other Long Term Care	0	o	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	o	0	0.00	0.00	8. 00
9.00	CMHC	0	o	0	0.00	0.00	9.00
10.00	HOSPI CE	0	o	0	0.00	0.00	10.00
11.00	Other excluded areas	897, 450	o	897, 450	35, 596. 00	25. 21	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	897, 450	o	897, 450	35, 596. 00	25. 21	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	3, 639, 260	0	3, 639, 260	149, 364. 00	24. 37	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	514, 916		514, 916	10, 247. 00		
15. 00	Contract Labor: Physician services-Part A	15, 840		15, 840	96. 00		
16. 00	Home office salaries & wage related costs	0	0	0	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS		. 1				
	Wage-related costs core (See Part IV)	1, 516, 165	0	1, 516, 165			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18.00
19. 00	Wage related costs (excluded units)	299, 927	0	299, 927			19.00
20. 00	Physician Part A - WRC	0	0	0			20.00
21. 00	Physician Part B - WRC	0	0	0			21.00
22. 00	Total Adjusted Wage Related cost (see	1, 216, 238	0	1, 216, 238			22.00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION HOUSE OF THE GOOD SHEPHERD

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: | Part | Par Provi der No.: 315422

				''	0 12/31/2021	5/26/2022 4: 3	
	·	Amount	Reclass. of	Adj usted	Pai d Hours	Average	
		Reported	Salaries from	Sal ari es	Related to	Hourly Wage	
			Worksheet A-6	(col. 1 ±	Salary in	(col. 3 ÷	
				col. 2)	col. 3	col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0. 00	0. 00	1.00
2.00	Administrative & General	860, 517	0	860, 517	28, 769. 00	29. 91	2.00
3.00	Plant Operation, Maintenance & Repairs	363, 274	0	363, 274	17, 218. 00	21. 10	3.00
4.00	Laundry & Linen Service	46, 366	0	46, 366	2, 362. 00	19. 63	4.00
5.00	Housekeepi ng	203, 996	0	203, 996	13, 058. 00	15. 62	5.00
6.00	Di etary	591, 767	0	591, 767	40, 136. 00	14. 74	6. 00
7.00	Nursing Administration	255, 277	0	255, 277	7, 001. 00	36. 46	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
10.00	Medical Records & Medical Records Library	0	0	0	0. 00	0.00	10.00
11. 00	Soci al Servi ce	68, 855	0	68, 855	1, 991. 00	34. 58	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	201, 038	0	201, 038	9, 666. 00	20. 80	13.00
14. 00	Total (sum lines 1 thru 13)	2, 591, 090	0	2, 591, 090	120, 201. 00	21. 56	14.00

Health Financial Systems	HOUSE OF THE GOOD SHEPHERD	In Lieu	ı of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315422	From 01/01/2021	Worksheet S-3 Part IV Date/Time Prepared:

	To 12/31/		
		Amount	
		Reported	
		1. 00	
PAR	RT IV - WAGE RELATED COSTS		
Par	t A - Core List		
RET	TREMENT COST		
. 00 401	1K Employer Contributions	C	1.00
	x Sheltered Annuity (TSA) Employer Contribution		2.00
. 00 Qua	alified and Non-Qualified Pension Plan Cost	240, 585	3.00
00 Pri	or Year Pension Service Cost		4.00
PLA	N ADMINISTRATIVE COSTS (Paid to External Organization)		
	1K/TSA Plan Administration fees	C	5.00
. 00 Lec	gal/Accounting/Management Fees-Pension Plan		
	oloyee Managed Care Program Administration Fees		1
	NLTH AND INSURANCE COST		7.00
	alth Insurance (Purchased or Self Funded)	609, 535	8.00
	escription Drug Plan	007,000	
	ntal, Hearing and Vision Plan	12, 270	
	fe Insurance (If employee is owner or beneficiary)	12, 213	
	cident Insurance (If employee is owner or beneficiary)	12, 213	1
	sability Insurance (If employee is owner or beneficiary)	7, 249	
	ng-Term Care Insurance (If employee is owner or beneficiary)	7,247	1
	rkers' Compensation Insurance	217, 543	
	tirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 10		
	n cumulative portion)	56.	10.00
TAX			
		366, 908	17.00
	CA-Employers Portion Only	300, 908	
	dicare Taxes - Employers Portion Only		
	employment Insurance	49, 862	
D. OO Sta OTH	ate or Federal Unemployment Taxes	C	20.00
			21.00
	ecutive Deferred Compensation	-	
	y Care Cost and Allowances	C	
	tion Reimbursement	C	
1.00 lot	tal Wage Related cost (Sum of lines 1 - 23)	1, 516, 165	24.00
		Amount	
		Reported	
		1.00	
	t B - Other than Core Related Cost		
5. 00 OTH	HER WAGE RELATED COST		25.00

SHEPHERD In Lieu of Form CMS-2540-10
Provider No.: 315422 Period: Worksheet S-3
From 01/01/2021 Part V
To 12/31/2021 Date/Time Prepared:

				To	12/31/2021	Date/Time Pre 5/26/2022 4:3	
	Occupational Category	Amount	Fri nge	Adjusted	Pai d Hours	Average	ı pııı
		Reported	Benefits	Sal ari es	Related to	Hourly Wage	
				(col. 1 +	Salary in	(col. 3 ÷	
				col . 2)	col. 3	col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	347, 504	116, 136	· ·	6, 143. 00	75. 47	1.00
2.00	Licensed Practical Nurses (LPNs)	165, 367	55, 266		3, 707. 00	59. 52	2.00
3.00	Certified Nursing Assistant/Nursing	535, 299	178, 897	714, 196	19, 312. 00	36. 98	3.00
	Assi stants/Ai des						
4. 00	Total Nursing (sum of lines 1 through 3)	1, 048, 170	350, 299	1, 398, 469	29, 162. 00	47. 96	
5.00	Physical Therapists	0	0	0	0. 00	0. 00	
6. 00	Physical Therapy Assistants	0	0	0	0. 00	0. 00	
7. 00	Physical Therapy Aides	0	0	0	0. 00	0. 00	
8.00	Occupational Therapists	0	0	0	0. 00	0. 00	
9.00	Occupational Therapy Assistants	0	0	0	0. 00	0. 00	9.00
10.00	Occupational Therapy Aides	0	0	0	0. 00	0. 00	10.00
11. 00	Speech Therapists	0	0	0	0. 00	0. 00	11.00
12.00	Respiratory Therapists	0	0	0	0. 00	0. 00	
13.00	Other Medical Staff	0	0	0	0. 00	0. 00	13.00
	Contract Labor						
4.4.00	Nursing Occupations	4 400			20.00	45.00	
14.00	Registered Nurses (RNs)	1, 432		1, 432	22. 00	65. 09	
15.00	Licensed Practical Nurses (LPNs)	13, 320		13, 320	242. 00	55. 04	
16. 00	Certified Nursing Assistant/Nursing	4, 094		4, 094	117. 00	34. 99	16. 00
17. 00	Assistants/Aides	10 044		18. 846	381. 00	49. 46	17. 00
	Total Nursing (sum of lines 14 through 16)	18, 846		-,	864. 00		17.00
18. 00 19. 00	Physical Therapy Assistants	47, 514		47, 514		54. 99	19.00
20.00	Physical Therapy Assistants	105, 587		105, 587 0	2, 030. 00 0. 00	52. 01 0. 00	
21.00	Physical Therapy Aides Occupational Therapists	147, 681		147, 681	2, 761. 00	53. 49	
21.00		151, 921		151, 921	2, 761.00 3, 617.00	42. 00	
23. 00	Occupational Therapy Asis stants	131, 921		151, 921	0.00	0.00	
24. 00	Speech Therapists	43, 367		43, 367	594. 00	73. 01	
25. 00	Respiratory Therapists	43, 307		43, 307	0.00	0.00	
	Other Medical Staff			0	0.00		26. 00
20.00	Other Wedical Starr	١		ı Y	0.00	0.00	20.00

From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 4:31 pm Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 **RVL** 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 **RUC** 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 **RVA** 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RI A 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE₂ 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC₂ 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB₂ 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 CA1 52.00 SE3 53.00 53.00 54.00 SE2 54.00 55.00 SE1 55.00 SSC 56.00 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 64.00 BB1 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 PE1 68.00 68.00 69.00 PD2 69.00 70.00 PD1 70.00 PC2 71.00 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00

75.00

PA₂

75.00

Health Financial Systems	HOUSE OF THE GOOD	SHEPHERD		In Lie	u of Form CMS-	2540-10	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315422	Peri od:	Worksheet S-7	1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 4:3		
				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. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101. 00 Staffi ng						101.00	
102.00 Recruitment						102.00	
103.00 Retention of employees						103.00	
104. 00 Trai ni ng						104.00	
105. 00 OTHER (SPECIFY)						105.00	
106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)		I	1		106. 00	

Heal th	Financial Systems	HOUSE OF THE GOO	D SHEPHERD		In Lie	u of Form CMS-2	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF				Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
						5/26/2022 4: 3	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance	
				+ COI. 2)	Increase/Decr	(col. 3 +-	
					ease (Fr Wkst	col . 4)	
					A-6)		
	CENEDAL CEDALCE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES		1, 253, 358	1, 253, 35	8 0	1, 253, 358	1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 233, 330	1, 255, 55	0 0	1, 255, 550	2.00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 516, 165	1, 516, 16	5 0	1, 516, 165	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	860, 517	1, 832, 538	2, 693, 05	5 0	2, 693, 055	4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	363, 274	943, 058			1, 306, 332	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	46, 366	129, 887			176, 253	
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	203, 996 591, 767	35, 072 870, 921	239, 06 1, 462, 68		239, 068 1, 462, 688	7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	255, 277	670, 921 0	255, 27		255, 277	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	255, 277	63, 608			30, 205	
11. 00	01100 PHARMACY	O	5, 701	5, 70		5, 701	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	1, 835	1, 83	5 0	1, 835	12.00
13.00	01300 SOCI AL SERVI CE	68, 855	0	68, 85		68, 855	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14.00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	201, 038	10, 691	211, 72	9 0	211, 729	15.00
30. 00	03000 SKILLED NURSING FACILITY	1, 048, 170	199, 909	1, 248, 07	9 0	1, 248, 079	30.00
31. 00	03100 NURSING FACILITY	0	0		ó	0	31.00
32.00	03200 CF/IID	0	0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0		0 10, 412	10, 412	
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0		0 22, 991	22, 991 0	
43.00	04300 OXYGEN (INHALATION) THERAPY		5, 456	5, 45	6 0	5, 456	
44. 00	04400 PHYSI CAL THERAPY	l o	497, 703				
45.00	04500 OCCUPATI ONAL THERAPY	o	0	1	0 300, 588	300, 588	
46.00	04600 SPEECH PATHOLOGY	0	0		0 43, 510	43, 510	
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	D 011	F2 01	0	0	48.00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY		53, 911	53, 91	0 0	53, 911 0	1
51.00	05100 SUPPORT SURFACES		0		0 0	-	51.00
011.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		
60.00	06000 CLI NI C	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
62. 00	06200 FOHC						62.00
70 00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	O	0		0 0	0	70.00
	07100 AMBULANCE		0		0 0		
73.00	07300 CMHC		0		0 0		
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	
81. 00	08100 I NTEREST EXPENSE		0		0	0	
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0	0	82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	2 420 240	7 410 013	11 050 07	0	11 050 073	
69.00	NONREI MBURSABLE COST CENTERS	3, 639, 260	7, 419, 813	11, 059, 07	3 0	11, 059, 073	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		Ö		o o	Ö	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY	0	0	225	0	0	
	09500 I LU/ALU	897, 450	98, 080			995, 530	1
100.00	TOTAL	4, 536, 710	7, 517, 893	12, 054, 60	3 0	12, 054, 603	1100.00

In Lieu of Form CMS-2540-10 HOUSE OF THE GOOD SHEPHERD

Health FinancialSystemsHOUSE OF TORECLASSIFICATIONAND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provider No.: 315422 | Period: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				To 12/31/2021	
	Cost Center Description	Adjustments	Net Expenses		5/26/2022 4: 31 pm
	South Control Boson Ptron	to Expenses	For		
		(Fr Wkst A-8)	Allocation		
			(col. 5 +-		
		/ 00	col. 6)		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES	-29, 873	1, 223, 485		1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	0		2.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 516, 165		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	-670, 118	· · · · · · · · · · · · · · · · · · ·		4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	-26, 578	1, 279, 754		5.00
6. 00	00600 LAUNDRY & LINEN SERVICE	-206	176, 047		6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	-907	238, 161		7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	-9, 102 -1, 134	1, 453, 586 254, 143		9.00
10. 00	01000 CENTRAL SERVICES & SUPPLY	-1, 134	30, 205		10.00
11. 00	01100 PHARMACY	0	5, 701		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	1, 835		12.00
13.00	01300 SOCIAL SERVICE	-306	68, 549		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		14.00
15. 00	01500 ACTI VI TI ES	-893	210, 836		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		4 040 404		
30.00	03000 SKILLED NURSING FACILITY	-4, 658 0	, , , , ,		30.00
31. 00 32. 00	03100 NURSI NG FACI LI TY	0	0		31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		33.00
00.00	ANCILLARY SERVICE COST CENTERS		<u> </u>		38. 88
40.00	04000 RADI OLOGY	0	10, 412		40.00
41.00	04100 LABORATORY	-3, 071	19, 920		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		42.00
	04300 OXYGEN (INHALATION) THERAPY	0	5, 456		43.00
44.00	04400 PHYSI CAL THERAPY	0	153, 605		44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	300, 588 43, 510		45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	43, 510		47.00
48. 00	1 1	0	0		48.00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	53, 911		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51. 00		0	0		51.00
	OUTPATIENT SERVICE COST CENTERS	_			
60.00	06000 CLINIC	0	-1		60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS				82.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		70.00
71. 00	07100 AMBULANCE	0	o		71.00
73.00	07300 CMHC	0	0		73. 00
	SPECIAL PURPOSE COST CENTERS				
	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0			80.00
	08100 I NTEREST EXPENSE	0	0		81.00
82. 00 83. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0		82. 00 83. 00
89.00	SUBTOTALS (sum of lines 1-84)	-746, 846	· · · · · · · · · · · · · · · · · · ·		89.00
57.00	NONREI MBURSABLE COST CENTERS	, 770, 040	10, 012, 221		37.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		91.00
92.00		0	0		92.00
	09300 NONPALD WORKERS	0	0		93.00
	09400 PATIENTS LAUNDRY	0	001 543		94.00
95. 00 100. 00	09500 LU/ALU TOTAL	-3, 988 -750, 834			95. 00 100. 00
100.00	/ IUIAL	-750, 834	11, 303, 709		J100.00

Heal th	Financial Systems	HOUSE OF THE GOOD S	SHEPHERD		In Lie	u of Form CMS-2	2540-10
RECLAS	SSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 4:3	
				Increases			
		Cost Cente	r	Li ne #	Sal ary	Non Salary	
		2.00		3. 00	4. 00	5. 00	
	(1) A - TO RECLASS MISC THERAPY EXPENSE						
1.00		OCCUPATIONAL THERAF	PΥ	45. 0	0 0	986	1.00
2.00		SPEECH PATHOLOGY		46. 0	0 0	143	2.00
	(1) B - RECLASS SALARIED & CONTRACT THERAPY						
3.00		OCCUPATIONAL THERAF	PΥ	45. 0	0 0	299, 602	3.00
4.00		SPEECH PATHOLOGY		46. 0	0 0	43, 367	4.00
	(1) C - LAB AND XRAY						
5.00		RADI OLOGY		40. 0	0 0	10, 412	5.00
6.00		LABORATORY		41. (0 0	22, 991	6.00
	TOTALS						
100.00		Total Reclassificat	ions (Sum		0	377, 501	100.00
		of columns 4 and 5	must				
		equal sum of column	is 8 and				
		9)					

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

Heal th	Financial Systems	HOUSE OF	THE GOOD	SHEPHERD		In Lie	u of Form CMS-	2540-10
RECLAS:	SI FI CATI ONS			Provi der	No.: 315422	Peri od:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pro 5/26/2022 4:	epared: 31 pm
	·				Decreases			
			Cost Cente	r	Li ne #	Sal ary	Non Salary	
			6. 00		7. 00	8. 00	9. 00	
	(1) A - TO RECLASS MISC THERAPY EXPENSE	_						
1.00		PHYSI CAL	THERAPY		44. (00	986	1.00
2.00		PHYSI CAL	THERAPY		44. (00	143	2.00
	(1) B - RECLASS SALARIED & CONTRACT THERAPY							
3.00		PHYSI CAL	THERAPY		44. (00	299, 602	3.00
4.00		PHYSI CAL	THERAPY		44. (00	43, 367	4.00
	(1) C - LAB AND XRAY							
5.00		CENTRAL S	ERVICES &	SUPPLY	10. (00	10, 412	5.00
6.00		CENTRAL S	ERVICES &	SUPPLY	10. (00	22, 991	6.00
	TOTALS							
100.00						0	377, 50	100.00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS HOUSE OF THE GOOD SHEPHERD In Lieu of Form CMS-2540-10 Provi der No.: 315422

| Peri od: | Worksheet A-7 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					12/01/2021	5/26/2022 4: 31	
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE						
1. 00	Land	328, 328		(0	0	1.00
2.00	Land Improvements	2, 143, 301	138, 000		138, 000		2.00
3.00	Buildings and Fixtures	25, 590, 032	690, 988	(690, 988	2, 707	3.00
4.00	Building Improvements	0	0	(0	0	4.00
5.00	Fixed Equipment	0	0	(0	0	5.00
6.00	Movable Equipment	3, 664, 013	55, 613	(55, 613		6.00
7.00	Subtotal (sum of lines 1-6)	31, 725, 674	884, 601	(884, 601	2, 707	7.00
8.00	Reconciling Items	0	0	(0	0	8.00
9. 00	Total (line 7 minus line 8)	31, 725, 674	884, 601	(884, 601	2, 707	9. 00
	Description	Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE						
1. 00	Land	328, 328	0				1.00
2.00	Land Improvements	2, 281, 301	0				2.00
3.00	Buildings and Fixtures	26, 278, 313	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	3, 719, 626	0				6.00
7.00	Subtotal (sum of lines 1-6)	32, 607, 568	0				7.00
8.00	Reconciling Items	0	0				8.00
9. 00	Total (line 7 minus line 8)	32, 607, 568	0			I	9.00

Provi der No.: 315422 Peri od: Worksheet A-8 From 01/01/2021 | Worksheet A-8 | To 12/31/2021 | Date/Time Prepared:

				To 12/31/2021	Date/Time Pre 5/26/2022 4:3	
				Expense Classification on		ı pili
				To/From Which the Amount is		
	Description (1)	(2) Basis	Amount	Cost Center	Li ne No.	
		For				
		Adjustment				
		1. 00	2. 00	3. 00	4. 00	
1. 00	Investment income on restricted funds	В	-29, 873	CAP REL COSTS - BLDGS &	1. 00	1.00
	(chapter 2)			FIXTURES		
2. 00	Trade, quantity, and time discounts (chapter		0)	0. 00	2.00
0.00	8)		0.074	LABORATORY	44.00	0.00
3.00	Refunds and rebates of expenses (chapter 8)	В	-3, 0/1	LABORATORY	41. 00	3.00
4. 00	Rental of provider space by suppliers		Ü		0. 00	4. 00
F 00	(chapter 8)		7.4/0	A DAM AN CEDATIVE A CENEDAL	4 00	F 00
5. 00	Telephone services (pay stations excluded)	В	- / , 468	ADMINISTRATIVE & GENERAL	4. 00	5. 00
	(chapter 21)	D	24.074	DIANT ODERATION MAINT O	F 00	/ 00
6. 00	Television and radio service (chapter 21)	В	-24, 964	PLANT OPERATION, MAINT. &	5. 00	6. 00
7 00	Dardilar Lat (abantan 21)		0	REPAI RS	0.00	7 00
7. 00 8. 00	Parking Lot (chapter 21)	100	0	l .	0. 00	7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	U			8. 00
9. 00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0		0.00	
11.00	Capi tal expendi tures (chapter 24)		U		0.00	11.00
12.00	Adjustment resulting from transactions with	A-8-1	0			12.00
12.00	related organizations (chapter 10)	A-0-1	O			12.00
13.00	Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals		0		0.00	
15. 00	Cost of meals - Guests	В	-6. 472	DI ETARY	8. 00	
16. 00	Sale of medical supplies to other than		0, 1,2)		16. 00
	pati ents		_			
17.00	1 -		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Vending machines		0		0.00	19.00
20.00	Income from imposition of interest, finance		0		0.00	
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		0		0.00	21.00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82. 00	22.00
	(chapter 21)					
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1. 00	23.00
				FIXTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2. 00	24.00
25 00	NON ALLOW EVE	_	/10 200	EQUI PMENT	4 00	25 22
25. 00	NON-ALLOW EXP	A		ADMINISTRATIVE & GENERAL		25. 00 25. 01
25. 01	MISC INCOME	В		ADMINISTRATIVE & GENERAL		
25. 02	ADMI NI STRATI VE SERVI CES	В		ADMINISTRATIVE & GENERAL	1	25. 02
25. 03	RENTAL INCOME	В		ADMINISTRATIVE & GENERAL	4.00	
25. 04 25. 05	EMLOYEE BONUS GIFTS EMLOYEE BONUS GIFTS	B B		ADMINISTRATIVE & GENERAL	4.00	
25. 05	EMPOSEE BOMOS GIFTS	В	-1,014	PLANT OPERATION, MAINT. &	5. 00	25. 05
25. 06	EMLOYEE BONUS GIFTS	В	204	REPAIRS LAUNDRY & LINEN SERVICE	6. 00	25. 06
25. 07	EMLOYEE BONUS GIFTS	В		HOUSEKEEPING	7.00	
25. 07	EMLOYEE BONUS GIFTS	В		DIETARY	8.00	
25. 09	EMLOYEE BONUS GIFTS	В	•	NURSING ADMINISTRATION	9. 00	
25. 10	EMLOYEE BONUS GIFTS	В		SOCIAL SERVICE	13. 00	
25. 10	EMLOYEE BONUS GIFTS	В		BACTI VI TI ES	15. 00	
25. 11	1	В		SKILLED NURSING FACILITY	30.00	
25. 12	1	В		BILU/ALU		25. 12
	Total (sum of lines 1 through 99) (Transfer		-750, 834		/3. 30	100.00
. 55. 50	to Worksheet A, col. 6, line 100)		, 55, 554			. 55. 66
(1) De	scrintion - all chanter references in this co	Jumn nertain to	n CMS Pub 15_	.1		

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

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

B. Amount Received - if cost cannot be determined.

SHEPHERD In Lieu of Form CMS-2540-10
Provider No.: 315422 Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					То	12/31/2021	Date/Time Pre	pared:
			CAPITAL REL	ATED COSTS			5/26/2022 4: 3	ı pili
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE		EMPLOYEE	Subtotal	
	cost center bescription	for Cost	FI XTURES	EQUI PMENT		BENEFITS	Subtotal	
		Allocation						
		(from Wkst A						
		col. 7)	1. 00	2. 00		3. 00	3A	
	GENERAL SERVICE COST CENTERS					2.22	-	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	1, 223, 485	1, 223, 485					1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	1, 516, 165	0		0	1, 516, 165		2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	2, 022, 937	0		0	287, 584	2, 310, 521	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 279, 754	0		0	121, 406	1, 401, 160	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	176, 047	0		0	15, 495	191, 542	6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	238, 161 1, 453, 586	0		0	68, 175 197, 768	306, 336 1, 651, 354	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	254, 143	0		0	85, 313	339, 456	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	30, 205	0		0	0	30, 205	10.00
11.00	01100 PHARMACY	5, 701	0		0	0	5, 701	11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	1, 835 68, 549	0		0	23, 011	1, 835 91, 560	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	00, 547	0		0	23, 011	91, 300	14. 00
15. 00	01500 ACTI VI TI ES	210, 836	0		0	67, 187	278, 023	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	1, 243, 421	402, 857 0		0	350, 299 0	1, 996, 577 0	30. 00 31. 00
32. 00	03200 CF/IID		0		0	o	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS					_1		
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	10, 412 19, 920	0		0	0	10, 412 19, 920	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	19, 920	0		0	ol	19, 920	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	5, 456	0		0	o	5, 456	43.00
44.00	04400 PHYSI CAL THERAPY	153, 605	0		0	0	153, 605	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	300, 588 43, 510	0		0	0	300, 588 43, 510	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	43, 310	0		0	o	43, 310	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	o	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	53, 911	0		0	0	53, 911	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0	0	0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	0	<u> </u>		<u> </u>	<u> </u>	0	31.00
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	O6200 FQHC OTHER REIMBURSABLE COST CENTERS							62.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	o	0	71. 00
73. 00	07300 CMHC	0	0		0	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES							80. 00
81. 00	08100 I NTEREST EXPENSE							81.00
82. 00	08200 UTILIZATION REVIEW - SNF							82.00
83.00	08300 HOSPI CE	0	402.057		0	0	0 101 (72	83.00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	10, 312, 227	402, 857		0	1, 216, 238	9, 191, 672	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	0	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0	0	0	92. 00 93. 00
94.00	09400 PATI ENTS LAUNDRY		0		0	ol Ol	0	93.00
95.00	09500 I LU/ALU	991, 542	820, 628		Ö	299, 927	2, 112, 097	95.00
98.00	Cross Foot Adjustments	0	0		0	0	0	98.00
99. 00 100. 00	Negative Cost Centers TOTAL	11, 303, 769	0 1, 223, 485		0	0 1, 516, 165	0 11, 303, 769	99. 00 100. 00
100.00	, TOTAL	11, 303, 709	1, 223, 403	l	٩	1, 310, 100	11, 303, 707	100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315422 | Period: | Worksheet B | From 01/01/2021 | Part | To | 13/21/2021 | Part /Time Pr

				T T	rom 01/01/2021 o 12/31/2021		
	Cost Center Description	ADMINISTRATIV E & GENERAL	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	2, 310, 521 359, 982 49, 210 78, 703 424, 261 87, 212 7, 760 1, 465 471 23, 523 0 71, 429	1, 761, 142 0 0 0 0 0 0 0 0 0	240, 752 0 0 0 0 0 0 0 0	385, 039 0 0 0 0 0 0 0	2, 075, 615 0 0 0 0 0 0 0	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	F40 0FF	F70 000	140 404	4/4 057	407.070	
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	512, 955 0 0 0	579, 892 0 0 0	118, 431 0 0 0	164, 957 0 0 0	406, 978 0 0	30. 00 31. 00 32. 00 33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	2 (75		1 0	٥١	0	40.00
40. 00 41. 00 42. 00 43. 00 44. 00	O4000 RADI OLOGY O4100 LABORATORY O4200 INTRAVENOUS THERAPY O4300 OXYGEN (INHALATION) THERAPY O4400 PHYSI CAL THERAPY	2, 675 5, 118 0 1, 402 39, 464	0 0 0 0	0	0 0 0 0	0 0 0 0	40. 00 41. 00 42. 00 43. 00 44. 00
45. 00 46. 00 47. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	77, 226 11, 178 0	0	0	0 0	0	45. 00 46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	13, 851	0	0	Ö	0	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0 0	0	50. 00 51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS O6000 CLINIC	O	0	0	ol	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	o	0		0	0	61. 00 62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	0	ol	0	70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0 0	0	0	0	0	70. 00 71. 00 73. 00
	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 1, 767, 885	579, 892	0 118, 431	0 164, 957	0 406, 978	83. 00 89. 00
91. 00 92. 00 93. 00 94. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0 0 0 0	0 0 0 0	0 0	0 0 0 0	0 0 0 0	91. 00 92. 00 93. 00 94. 00
95.00	09500 I LU/ALU	542, 636	1, 181, 250	122, 321	220, 082	1, 668, 637	1
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98. 00 99. 00
100.00		2, 310, 521	1, 761, 142	240, 752	385, 039	2, 075, 615	

Provi der No.: 315422

| Peri od: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Ti me Prepared: 5/26/2022 4:31 pm

				10	12/31/2021	5/26/2022 4: 3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY		
		9. 00	10. 00	11. 00	12.00	13. 00	
<u></u>	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION	426, 668					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	37, 965				10.00
11. 00	01100 PHARMACY		0,,,00	7, 166			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0	0	2, 306		12.00
13. 00	1		Ö	0	2, 000	115, 083	1
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0	0	0	0	14.00
15. 00	01500 ACTIVITIES		0	0	0	0	15.00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	O ₁	<u> </u>		13.00
30. 00	03000 SKILLED NURSING FACILITY	336, 227	34, 262	7, 166	2, 306	79, 651	30.00
31. 00	03100 NURSING FACILITY	0	0	7, 100	2, 300	77,031	31.00
32. 00	03200 CF/11 D		0	0	0	0	32.00
33. 00	1 1	0	0	0	0	0	33.00
33.00	ANCILLARY SERVICE COST CENTERS	ı v	υ	U	υĮ	0	33.00
40.00	04000 RADI OLOGY	O	ol	0	ol	0	40.00
40.00	04100 LABORATORY		0	0	0	0	40.00
41. 00	04200 I NTRAVENOUS THERAPY	0	U	0	O O	0	41.00
42. 00	1	0	U	0	O O	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	U	0	O O	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	U	0	O O	0	44. 00 45. 00
	1	0	U	0	O O		1
46. 00	04600 SPEECH PATHOLOGY	0	U	0	0	0	46.00
47. 00	04700 ELECTROCARDI OLOGY	0	222	0	0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	323	0	0	0	48.00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	U	0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	U	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES	l U	U	U	U	0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS	1 0	ما	0	ما	0	/ 0 00
60.00	06000 CLINIC	0	0	0	0	0	60.00
61.00		0	0	0	0	0	61.00
62. 00							62.00
70.00	OTHER REIMBURSABLE COST CENTERS		ما		ام		70.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	1	0	0	0	0	0	71.00
73. 00		0	0	0	0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS	1	1				00 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00							82.00
83.00	1	0	0	0	0	0	•
89. 00		336, 227	34, 585	7, 166	2, 306	79, 651	89. 00
	NONREI MBURSABLE COST CENTERS	1 0	- I		ام		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500 I LU/ALU	90, 441	3, 380	0	0	35, 432	
98.00	Cross Foot Adjustments	0	0		_		98.00
99.00		0	0	0	0	0	99.00
100.00	D TOTAL	426, 668	37, 965	7, 166	2, 306	115, 083	100.00

SHEPHERD In Lieu of Form CMS-2540-10
Provider No.: 315422 Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				Ť	o 12/31/2021	Date/Time Pre	
			OTHER GENERAL			5/26/2022 4: 3	I DIII
			SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		EDUCATION			Adjustments		
		14. 00	15. 00	16.00	17.00	18. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 2.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINI STRATI VE & GENERAL						4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6. 00 7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY						11. 00 12. 00
13. 00	01300 SOCI AL SERVI CE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15. 00	01500 ACTI VI TI ES	0	349, 452				15.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0	288, 932	4, 528, 334	0	4, 528, 334	30.00
31. 00	03100 NURSING FACILITY	0	200, 732			4, 320, 334	31.00
32.00	03200 CF/IID	0	0			0	1
33.00	03300 OTHER LONG TERM CARE	0	0	C	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	13, 087	0	12 007	40.00
	04100 LABORATORY	0	0			13, 087 25, 038	1
42. 00	04200 I NTRAVENOUS THERAPY	0	Ö	20,000		0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	6, 858	0	6, 858	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	193, 069		193, 069	1
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0	377, 814 54, 688		377, 814 54, 688	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	34, 000		0 0 0	1
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	323	0	323	1
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	67, 762		67, 762	1
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			0	50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0	U) U	0	51.00
60.00	06000 CLI NI C	0	0	С	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	С	0	0	
62. 00	O6200 FOHC OTHER REIMBURSABLE COST CENTERS						62.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70.00
71.00	07100 AMBULANCE	0	0			0	71.00
73.00	07300 CMHC	0	0	c	0	0	73. 00
90 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	1					80.00
	08100 INTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0			0		
89. 00	SUBTOTALS (sum of lines 1-84)	0	288, 932	5, 266, 973	0	5, 266, 973	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 0	0		0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	ol			0	1
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0	C	0	0	
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 I LU/ALU	0	0 60, 520	6 024 704	0	0 6, 036, 796	
98.00	Cross Foot Adjustments	0	00, 520	l		0, 036, 796	1
99. 00	Negative Cost Centers	0	0		_	0	99.00
100.00	1 1 0	0	349, 452	11, 303, 769	0	11, 303, 769	100.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315422

				To	12/31/2021	Date/Time Pre 5/26/2022 4:3	
			CAPI TAL REI	LATED COSTS		3/20/2022 4.3	, piii
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	FIXTURES	EQUI PMENT	Subtotal	BENEFI TS	
		Capi tal					
		Related Costs 0	1. 00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	ZA	3.00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS		0	o	0	0	2.00 3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0	Ö	0	0	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	0	0	0	0	0	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00	01100 PHARMACY	0	0	0	0	0	11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	0	0	0	0	12.00 13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	0	0	0	0	0	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		402.057	I al	402.057	0	1 20 00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	402, 857 0		402, 857 0	0	30.00 31.00
32. 00	03200 CF/IID	o	0		0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCILLARY SERVICE COST CENTERS	0	0		0	0	40.00
41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0	- 1	0	0	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	Ö	0	Ö	0	0	42.00
43.00		0	0	0	0	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47. 00		0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0 0	0	0	49. 00 50. 00
51. 00		0	0	- 1	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0		0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71.00	07100 AMBULANCE	0	0		0	0	71.00
73.00	O7300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	73.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82.00			0		0	0	82.00
83. 00 89. 00		0	402, 857	0	402, 857	0	83. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	102, 007	<u> </u>	102, 007		07.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1	0	0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	91.00
93.00			0		0	0	92.00 93.00
94.00	09400 PATIENTS LAUNDRY	0	0	O	0	0	94. 00
95.00		0	820, 628	0	820, 628	0	95.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		0	o	0	0	98. 00 99. 00
100.00		О	1, 223, 485		1, 223, 485	_	100.00
			-	. '	•		•

Heal th Financial Systems

HOUSE OF THE GOOD SHEPHERD

In Lieu of Form CMS-2540-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315422
Period:
From 01/01/2021
To 12/31/2021
Part II
Date/Time Prepared:
5/26/2022 4: 31 pm

Cost Center Description

ADMINISTRATIV
E & GENERAL
OPERATION,
MAINT. &
REPAIRS

REPAIRS

In Lieu of Form CMS-2540-10

Worksheet B
Part II
Date/Time Prepared:
5/26/2022 4: 31 pm

DI ETARY

DI ETARY

						5/26/2022 4: 3	1 pm
	Cost Center Description	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
		4. 00	5. 00	6. 00	7. 00	8. 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 ADMINI STRATI VE & GENERAL	o					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	o	0				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	l ol	0	0			6. 00
7. 00	00700 HOUSEKEEPI NG	0	0	0	0		7. 00
8. 00	00800 DI ETARY	l ol	0	Ō	0	0	8. 00
9. 00	00900 NURSING ADMINISTRATION	أما	0	0	0	Ō	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		0	0	0	Ö	10. 00
11. 00	01100 PHARMACY		0	1	0	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		0		0	0	12.00
	01300 SOCI AL SERVI CE		0		0	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION		0	ő	0	Ö	14. 00
15. 00	01500 ACTIVITIES		0	1		0	15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	ı v	U	<u> </u>	U	U	13.00
20.00	03000 SKILLED NURSING FACILITY	1 0		ı o	0		20.00
30.00		0	0			0	30.00
31.00	03100 NURSING FACILITY	0	0		-	0	31.00
32. 00	03200 CF/IID	0	0	1		0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
		0	0	l .		0	40.00
41. 00	04100 LABORATORY	0	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	o	0	0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	o	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	o	0	0	0	0	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	l	0	O	0	0	50.00
51. 00	05100 SUPPORT SURFACES	l ol	0	1		0	51. 00
	OUTPATIENT SERVICE COST CENTERS	-1					
60.00	06000 CLI NI C	O	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0			Ö	61. 00
62. 00	06200 FQHC	Ĭ	· ·	Ĭ	o o		62.00
02.00	OTHER REIMBURSABLE COST CENTERS	l l					02.00
70. 00	07000 HOME HEALTH AGENCY COST	O	0	0	0	0	70. 00
	07100 AMBULANCE		0	1		ő	71.00
	07300 CMHC		0	l .		0	73.00
73.00	SPECIAL PURPOSE COST CENTERS	l ol		1 0	U	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 INTEREST EXPENSE						
81.00							81.00
	08200 UTI LI ZATI ON REVI EW - SNF		0		0	0	82.00
	08300 H0SPI CE	0	0	1			83.00
89. 00	SUBTOTALS (sum of lines 1-84)	0	0	0	0	0	89. 00
	NONREI MBURSABLE COST CENTERS			1	_	_	
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94. 00	09400 PATI ENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500 I LU/ALU	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments			0	0	0	
99. 00	Negative Cost Centers	0	0		-	0	
100.00	D TOTAL	0	0	0	0	0	100.00

Provi der No.: 315422

						5/26/2022 4: 3	1 pm
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION	0					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
	01000 CENTRAL SERVICES & SUPPLY		0				10.00
	01100 PHARMACY		0	0			11.00
	01200 MEDICAL RECORDS & LIBRARY		0	Ö	o		12.00
	01300 SOCIAL SERVICE	0	0	0	O	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	О	0	14.00
15. 00	01500 ACTI VI TI ES	0	0	0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 SKILLED NURSING FACILITY	0	0	0	_	0	30.00
	03100 NURSING FACILITY	0	0	0	_	0	31. 00
	03200 CF/IID	0	0	0		0	32.00
	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
+	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY	l ol	0	0	O	0	40.00
4	04100 LABORATORY		0	0	_	0	40. 00 41. 00
	04200 INTRAVENOUS THERAPY		0	0	0	0	42.00
1	04300 OXYGEN (INHALATION) THERAPY		0	0	o o	0	43.00
1	04400 PHYSI CAL THERAPY	0	0	O	o	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	o	0	0	o	0	45.00
4	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	l ol	U		U U	U	51.00
	06000 CLINIC	O	0	0	ol	0	60.00
	06100 RURAL HEALTH CLINIC		0	0		0	61.00
	06200 FQHC	1		Ī	_		62.00
Ī	OTHER REIMBURSABLE COST CENTERS	'			'		
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0	0	0		0	71.00
	07300 CMHC	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
4	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						81. 00 82. 00
4	08300 HOSPI CE		0	0	0	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)						1
	NONREI MBURSABLE COST CENTERS	١	<u> </u>		<u> </u>		07.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	o	0	0	o	0	91.00
4	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
	09300 NONPAI D WORKERS	0	0	0	-	0	93. 00
	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
	09500 I LU/ALU	0	0	0	0	0	95.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0 0	0	0 0		0	98. 00 99. 00
100.00	TOTAL		0				100.00
100.00	1.51712	١	O ₁	·	١	O	1.00.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315422

					To 12/31/2021	Date/Time Pre 5/26/2022 4:3	
			OTHER GENERAL			072072022 1. 0	, , p
			SERVI CE				
	Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post	Total	
		ALLI ED HEALTH			Step-Down		
		EDUCATI ON	15.00	1/ 00	Adjustments	10.00	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES			1			1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
	01500 ACTI VI TI ES	0	0	,			15.00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS			1			13.00
30.00	03000 SKILLED NURSING FACILITY	0	0	402, 85	7 0	402, 857	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 CF/IID	0	0		0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0)	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	0		1	0		1
41.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	ł	0		
42. 00 43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	ł	0 0	0 0	42. 00 43. 00
	04400 PHYSI CAL THERAPY	0				0	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	1
	04600 SPEECH PATHOLOGY	Ö	ĺ		o o	l o	1
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	1
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	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	•	0		50.00
51. 00	05100 SUPPORT SURFACES	0	0)	0 0	0	51.00
40.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1 0	1 0				40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0		0 0		1
62. 00	06200 FQHC		Ĭ		9	l	62.00
	OTHER REIMBURSABLE COST CENTERS	,			<u>'</u>		
	07000 HOME HEALTH AGENCY COST	0	0)	0	0	70. 00
	07100 AMBULANCE	0		•	0		
73. 00	07300 CMHC	0	0)	0 0	0	73.00
00 00	SPECIAL PURPOSE COST CENTERS		I	1			00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
	08200 UTI LI ZATI ON REVI EW - SNF						82.00
83. 00	08300 HOSPI CE	0	0		0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	Ö		•			
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1	0 0		
	09100 BARBER AND BEAUTY SHOP	0	0)	0	-	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	2	0	0	
	09300 NONPAI D WORKERS				0	0	
94. 00 95. 00	09400			920 42	0	0 820, 628	1
98.00	Cross Foot Adjustments			820, 62	0 0	820, 628	1
99.00	Negative Cost Centers	0	0	1	0 0		
100.00		0	Ö	1	-		
			•	•	*	*	

Heal th	Fi nar	icial Systems	HOUSE OF THE GO	OOD SH	HEPHERD		In Lie	u of Form CMS-	2540-10
		TION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1	
							From 01/01/2021 To 12/31/2021	Date/Time Pre	nared.
							10 12/31/2021	5/26/2022 4: 3	pareu. 1 pm
			CAPI TAL REL	ATED (COSTS				
			21222						
		Cost Center Description	BLDGS &		VABLE	EMPLOYEE		ADMI NI STRATI V	
			FIXTURES (SQUARE FEET)		IPMENT ALUE OR	BENEFITS (GROSS	n	E & GENERAL (ACCUM COST)	
			(SQUARE FEET)	-	FT)	SALARI ES)		(ACCOW COST)	
			1. 00		2. 00	3.00	4A	4. 00	
	GENER	AL SERVICE COST CENTERS					1		
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	119, 209						1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT			0)			2.00
3.00		EMPLOYEE BENEFITS	0		0	4, 536, 71			3.00
4. 00	1	ADMINISTRATIVE & GENERAL	0		0	860, 51		8, 993, 248	4. 00
5. 00	1	PLANT OPERATION, MAINT. & REPAIRS	0		0	363, 27		.,,	
6.00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0		0	46, 36		,	1
7. 00 8. 00	1	DI ETARY	0		0	203, 99 591, 76		306, 336 1, 651, 354	1
9. 00	1	NURSING ADMINISTRATION			0	255, 27		339, 456	1
10.00		CENTRAL SERVICES & SUPPLY	0		0	200, 27	0 0	30, 205	1
11.00		PHARMACY	0		0)	0	5, 701	1
12.00	01200	MEDICAL RECORDS & LIBRARY	0		0)	0 0	1, 835	12.00
13.00	01300	SOCIAL SERVICE	0		0	68, 85	5 0	91, 560	13.00
	1	NURSING AND ALLIED HEALTH EDUCATION	0		0)	0		
15. 00		ACTIVITIES	0		0	201, 03	8 0	278, 023	15.00
00.00		I ENT ROUTI NE SERVI CE COST CENTERS	20.050			1 040 47		4 00/ 577	
30.00		SKILLED NURSING FACILITY	39, 252		0	1, ,			30.00
		NURSING FACILITY ICF/IID	0		0	•	0 0		
		OTHER LONG TERM CARE	0		0	•	0 0		1
33.00		LARY SERVICE COST CENTERS	<u> </u>			'1	0		33.00
40.00		RADI OLOGY	0		0)	0 0	10, 412	40.00
41.00		LABORATORY	0		0		0 0		
42.00	04200	INTRAVENOUS THERAPY	0		0)	0	0	42.00
		OXYGEN (INHALATION) THERAPY	0		0		0	5, 456	
		PHYSI CAL THERAPY	0		0	l .	0	,	
		OCCUPATI ONAL THERAPY	0		0		0	300, 588	
	1	SPEECH PATHOLOGY	0		0	1	0	43, 510	1
		ELECTROCARDI OLOGY	0		0	1	0 0	0	
		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0		0		0 0	0 53, 911	1
		DENTAL CARE - TITLE XIX ONLY	0		0	•	0 0		1
		SUPPORT SURFACES	0		0	l	o o		
		TIENT SERVICE COST CENTERS	-,			1	-		1
60.00	06000	CLI NI C	0		0)	0 0	0	60.00
61.00		RURAL HEALTH CLINIC	0		0)	0	0	
62. 00	06200								62.00
70.00		REIMBURSABLE COST CENTERS							70.00
	1	HOME HEALTH AGENCY COST	0		0	1	0 0	1	1
	07300	AMBULANCE	0		0		0 0		
73.00		AL PURPOSE COST CENTERS	<u> </u>			'1	0 0	· · · · · ·	75.00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES							80.00
		INTEREST EXPENSE							81.00
82.00	08200	UTILIZATION REVIEW - SNF							82.00
83.00	08300	HOSPI CE	0		0		0	0	83.00
89. 00		SUBTOTALS (sum of lines 1-84)	39, 252		0	3, 639, 26	0 -2, 310, 521	6, 881, 151	89.00
00.00		I MBURSABLE COST CENTERS							00.00
	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0		0		0 0	l	1
		PHYSICIANS PRIVATE OFFICES	0		0	1	0 0		
	1	NONPALD WORKERS	0		0	1	0 0	Ö	
		PATIENTS LAUNDRY	0		0		o o		
95.00	09500	I LU/ALU	79, 957		0	897, 45	0	2, 112, 097	95.00
98.00		Cross Foot Adjustments							98.00
99. 00		Negative Cost Centers							99.00
102.00)	Cost to be allocated (per Wkst. B,	1, 223, 485		0	1, 516, 16	5	2, 310, 521	102.00
102.00	,	Part I)	10.0/00/1		0.000000	0.33440		0.05/047	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	10. 263361		0. 000000	0. 33419	7	0. 256917	1
104.00	1	Cost to be allocated (per Wkst. B, Part II)				1			104.00
105.00		Unit cost multiplier (Wkst. B, Part				0. 00000	o	0. 000000	105.00
	•	:				•	•		•

Health Financial Systems HOUSE OF THE GOOD SHEPHERD In Lieu of Form CMS-2540-10 COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315422 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 4:31 pm Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG OPERATI ON, LINEN SERVICE (CLEANED SQ (MEALS ADMI NI STRATI O MAINT. & (POUNDS OF FEET) SERVED) (TIME SPENT) **REPAURS** LAUNDRY) (SQUARE FEET) 5.00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2 00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 119, 209 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 153, 793 6.00 7.00 00700 HOUSEKEEPI NG 0 91,621 7.00 00800 DI ETARY 0 122, 570 8.00 8.00 00900 NURSING ADMINISTRATION 0 7,001 9 00 9 00 C 0 10.00 01000 CENTRAL SERVICES & SUPPLY 0 C 0 0 0 10.00 11.00 01100 PHARMACY 0 0 0 0 11.00 0 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 C 0 12.00 01300 SOCIAL SERVICE 0 0 13.00 C 0 13.00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 14.00 15.00 01500 ACTI VI TI ES 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 39, 252 75, 654 39, 252 24, 033 5, 517 30.00 03100 NURSING FACILITY 31.00 0 0 31.00 0 03200 | CF/IID 32.00 32.00 0 0 0 0 0 03300 OTHER LONG TERM CARE 33.00 0 C 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 04000 RADI OLOGY 40.00 0 40.00 41 00 04100 LABORATORY 0 0 0 0 41 00 0 04200 I NTRAVENOUS THERAPY 0 0 0 42.00 0 0 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 44.00 0 0 0 0 0 0 0 44.00 04500 OCCUPATI ONAL THERAPY 45 00 0 45 00 0 04600 SPEECH PATHOLOGY 46.00 0 0 46.00 04700 ELECTROCARDI OLOGY 0 0 0 0 47.00 47.00 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 48.00 o 04900 DRUGS CHARGED TO PATIENTS 0 49 00 Ω 49 00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 C 0 0 0 50.00 05100 SUPPORT SURFACES 0 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 60.00 06000 CLI NI C 0 0 0 06100 RURAL HEALTH CLINIC 0 0 0 0 0 61.00 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 70.00 07000 HOME HEALTH AGENCY COST 0 \cap n 0 \cap 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 07300 CMHC 73.00 73.00 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83 00 08300 H0SPI CE Λ 83 00 SUBTOTALS (sum of lines 1-84) 39, 252 39, 252 24, 033 5, 517 89.00 89.00 75,654 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 C 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 09300 NONPALD WORKERS 0 93.00 93.00 0 0 0 09400 PATIENTS LAUNDRY 94.00 Λ 94.00 95.00 09500 I LU/ALU 79, 957 78, 139 52, 369 98, 537 1,484 95.00 98.00 Cross Foot Adjustments 98.00 99.00 99.00 Negative Cost Centers

1, 761, 142

14.773566

0.000000

240, 752

1.565429

0.000000

385, 039

4. 202519

0.000000

2, 075, 615

16. 934119

0.000000

426, 668 102. 00

0 104, 00

60. 943865 103. 00

0.000000 105.00

Part I)

Part II)

102.00

103.00

104.00

105.00

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

			HOUSE OF THE GO		N 045400 B		J OT FORM CMS-2	
COST	ILLOCA	TION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2021	Worksheet B-1	
						o 12/31/2021	Date/Time Pre	
		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	5/26/2022 4: 3 NURSI NG AND	I DIII
		·	SERVICES &	(COSTED REQ	RECORDS &	SERVI CE	ALLI ED HEALTH	
			SUPPLY	UIS)	LI BRARY	(TIME SPENT)	EDUCATI ON	
			(COSTED REQ UIS)		(TIME SPENT)		(ASSI GNED TIME)	
			10. 00	11. 00	12. 00	13.00	14. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						1.00
2. 00 3. 00		EMPLOYEE BENEFITS						3.00
4. 00	1	ADMINISTRATIVE & GENERAL						4.00
5.00		PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00		LAUNDRY & LINEN SERVICE						6.00
7. 00 8. 00	1	HOUSEKEEPI NG DI ETARY						7. 00 8. 00
9. 00		NURSING ADMINISTRATION						9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	69, 825					10.00
11.00	1	PHARMACY	0	5, 701				11.00
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	0	100 0			12. 00 13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION		0			0	1
15. 00	01500	ACTI VI TI ES	o	0	Ō	_	0	1
		ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	63, 014 0	5, 701 0	100 0		0	
32.00		ICF/IID	0	0			0	
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	
		LARY SERVICE COST CENTERS						
40. 00 41. 00		RADI OLOGY LABORATORY	0	0	0 0		0	
42. 00	1	INTRAVENOUS THERAPY	o	0	ő		0	
43.00		OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00		PHYSI CAL THERAPY	0	0	0		0	44.00
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0 0		0	45. 00 46. 00
	1	ELECTROCARDI OLOGY	o	0	Ö	_	0	47. 00
48.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	594	0	0	0	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0	0		0	
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0 0	0	_		0	
01.00		TIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		01.00
60.00		CLINIC	0	_	0		0	
61. 00 62. 00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
02.00		REIMBURSABLE COST CENTERS						02.00
70.00	1	HOME HEALTH AGENCY COST	0	0			0	
71. 00 73. 00		AMBULANCE CMHC	0	0	_		0	
73.00		AL PURPOSE COST CENTERS	<u> </u>	0	0	<u> </u>	0	73.00
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00		INTEREST EXPENSE						81.00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0	0	0	0	82. 00 83. 00
89. 00	00000	SUBTOTALS (sum of lines 1-84)	63, 608	5, 701	100		0	
		MBURSABLE COST CENTERS	_		_		_	
90. 00 91. 00	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0 0	0	_		0	
92.00		PHYSICIANS PRIVATE OFFICES	o	0			0	
93.00		NONPALD WORKERS	0	0	0	0	0	
94.00	1	PATIENTS LAUNDRY	0	0	0	-	0	
95. 00 98. 00	09500	ILU/ALU Cross Foot Adjustments	6, 217	0	0	613	0	95. 00 98. 00
99.00		Negative Cost Centers						99.00
102.00)	Cost to be allocated (per Wkst. B,	37, 965	7, 166	2, 306	115, 083	0	102.00
103.00		Part I) Unit cost multiplier (Wkst. B, Part I)	0. 543716	1 254072	23. 060000	57. 801607	0. 000000	102 00
103.00		Cost to be allocated (per Wkst. B,	0. 343/16	1. 256972 0	23.000000	37. 801807		104.00
		Part II)						
105. 00)	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105.00
	1	11)	ı l		I	ı I		I

HOUSE OF THE GOOD SHEPHERD In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315422 | Peri od: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: F/2//2023 4:21 pm

				To 12/31/2021 Date/Time Pre	
			OTHER GENERAL	072072022 1.0	Pill
			SERVI CE		
		Cost Center Description	ACTIVITIES (TIME SPENT)		
			(TIME SPENT) 15.00		
	GENER	AL SERVICE COST CENTERS	10.00		
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3.00	1	EMPLOYEE BENEFITS			3.00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS			4. 00 5. 00
6. 00	1	LAUNDRY & LINEN SERVICE			6.00
7.00	00700	HOUSEKEEPI NG			7. 00
8. 00	1	DI ETARY			8. 00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY			9. 00 10. 00
11. 00		PHARMACY			11.00
12. 00		MEDICAL RECORDS & LIBRARY			12.00
13.00	01300	SOCIAL SERVICE			13.00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION			14.00
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	9, 666		15.00
30.00		SKILLED NURSING FACILITY	7, 992		30.00
31. 00	1	NURSING FACILITY	0		31.00
32. 00		ICF/IID	0		32.00
33. 00		OTHER LONG TERM CARE	0		33.00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	0		40.00
41. 00	1	LABORATORY	0		41.00
42.00	1	INTRAVENOUS THERAPY	0		42.00
	1	OXYGEN (INHALATION) THERAPY	0		43.00
44. 00	1	PHYSI CAL THERAPY	0		44.00
45. 00 46. 00		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0		45. 00 46. 00
		ELECTROCARDI OLOGY	0		47.00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	O		48.00
49. 00	1	DRUGS CHARGED TO PATIENTS	0		49. 00
		DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00		SUPPORT SURFACES TIENT SERVICE COST CENTERS	0		51.00
60.00		CLINIC	0		60.00
61.00		RURAL HEALTH CLINIC	0		61.00
62. 00	06200				62.00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	O		70.00
		AMBULANCE	0		71.00
73. 00	1		O		73.00
		AL PURPOSE COST CENTERS			
		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE			80.00
		UTILIZATION REVIEW - SNF			81. 00 82. 00
83. 00		HOSPI CE	o		83.00
89. 00		SUBTOTALS (sum of lines 1-84)	7, 992		89. 00
		MBURSABLE COST CENTERS			
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0		90. 00 91. 00
91.00		PHYSICIANS PRIVATE OFFICES	0		91.00
93. 00		NONPAI D WORKERS	o		93.00
94.00	09400	PATIENTS LAUNDRY	O		94.00
95.00	09500	I LU/ALU	1, 674		95.00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers			98. 00 99. 00
102.00		Cost to be allocated (per Wkst. B,	349, 452		102.00
30		Part I)	3.11, 102		
103.00		Unit cost multiplier (Wkst. B, Part I)	36. 152700		103.00
104.00)	Cost to be allocated (per Wkst. B,	0		104. 00
105. 00		Part II) Unit cost multiplier (Wkst. B, Part	0. 000000		105. 00
		[11]			

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315422	Health Financial Systems HOUSE OF THE GOOD	SHEPHERD		In Lie	u of Form CMS-2	2540-10
To 12/31/2021 Date/Time Prepared: 5/26/2022 4:31 pm	RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der			Worksheet C	
Cost Center Description					Data (T)	
Total (from Wist B, Pt I, col 18)				0 12/31/2021	Date/IIMe Pre	parea: 1 nm
Wkst. B, Pt	Cost Center Description		Total (from	Total Charges		i piii
1, col. 18 col. 2				To take that good		
ANCILLARY SERVICE COST CENTERS			I, col. 18)			
40.00			1.00	2. 00	3. 00	
41. 00						
42. 00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42. 00 43. 00 04300 0XYGEN (INHALATION) THERAPY 6,858 5,456 1.256965 43. 00 04400 PHYSI CAL THERAPY 193,069 247,099 0.781343 44. 00 04500 0CCUPATI ONAL THERAPY 377,814 293,622 1.286736 45. 00 04500 0500 05000						
43. 00 04300 0XYGEN (INHALATION) THERAPY 6,858 5,456 1.256965 43. 00 44. 00 04400 PHYSI CAL THERAPY 193,069 247,099 0.781343 44. 00 45. 00 04500 OCCUPATI ONAL THERAPY 377,814 293,622 1.286736 45. 00 46. 00 04600 SPEECH PATHOLOGY 54,688 112,455 0.486310 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0.000000 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 323 300 1.076674 48. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS 67,762 64,758 1.046388 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0.000000 51. 00 51. 00 05100 SUPPORT SURFACES 0 0 0.000000 51. 00 60. 00 06000 CLINIC 0 0 0.000000 61. 00 61. 00 06200 FOHC 62. 00 61. 00 62. 00 62. 00 71. 00			25, 038	32, 733		
44. 00 04400 PHYSI CAL THERAPY 193, 069 247, 099 0. 781343 44. 00 45. 00 04500 0CCUPATI ONAL THERAPY 377, 814 293, 622 1. 286736 45. 00 04600 SPEECH PATHOLOGY 54, 688 112, 455 0. 486310 46. 00 04700 ELECTROCARDI OLOGY 0 0 0 0.000000 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0.000000 47. 00 04900 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 323 300 1. 076667 48. 00 04900 DRUGS CHARGED TO PATI ENTS 67, 762 64, 758 1. 046388 49. 00 05000 DENTAL CARE - TI TLE XI X ONLY 0 0 0 0.000000 50. 00 05100 SUPPORT SURFACES 0 0 0 0 0.000000 51. 00 000000 51. 00 000000 04000 CLI NI C 0 0 0.000000 05000 06100 RURAL HEALTH CLI NI C 062. 00 06200 FOHC 071. 00 07100 AMBULANCE 0 0 0.000000 71. 00 07100 0000000 71. 00 07100 0000000 71. 00 07100 0000000 71. 00 07100			·	-		
45. 00						
46. 00						
47. 00 04700 CLECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
48. 00			54, 688	112, 455		
49. 00 04900 DRUGS CHARGED TO PATIENTS 67, 762 64, 758 1. 046388 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0. 000000 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0. 000000 51. 00 OUTPATIENT SERVICE COST CENTERS 60. 00 06100 RURAL HEALTH CLINIC 62. 00 62. 00 06200 FOHC 62. 00 71. 00 07100 AMBULANCE 0 0 0. 000000 71. 00			(
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0						
51. 00 05100 SUPPORT SURFACES 0 0 0.0000000 51. 00			67, 762	64, 758		
OUTPATIENT SERVICE COST CENTERS O			(0		
60. 00				0	0.000000	51.00
61. 00 06100 RURAL HEALTH CLINIC 61. 00 62. 00 71. 00 07100 AMBULANCE 0 0.000000 71. 00 7						
62. 00 06200 FQHC 62. 00 71. 00 07100 AMBULANCE 0 0 0. 000000 71. 00			(0	0. 000000	
71. 00 07100 AMBULANCE 0 0 0. 000000 71. 00						
100.00 10tal 738,639 767,276 100.00				-	0. 000000	
	100.00 Iotal		738, 639	767, 276		100. 00

Health Financial Systems	HOUSE OF THE G				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/26/2022 4:3	epared: R1 nm
		Title	XVIII (1)	Skilled Nursing		л рііі
		11 110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Facility	113	
		Heal th Care Pr	rogram Charges		Program Cost	
			3 3		3	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col.	Part B (col.	
	to Charges			1 x col. 2)	1 x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					_
ANCILLARY SERVICE COST CENTERS					1	
40. 00 04000 RADI OLOGY	1. 205842			0 7, 073	l e	
41. 00 04100 LABORATORY	0. 764916			0 6, 165	l .	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 256965	1		0	0	
44. 00 O4400 PHYSI CAL THERAPY	0. 781343			0 48, 098	l .	
45. 00 04500 OCCUPATI ONAL THERAPY	1. 286736			0 86, 644	0	1
46. 00 04600 SPEECH PATHOLOGY	0. 486310			0 19, 116	l	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	•		0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 076667	0		0	0	1 .0.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 046388			0 25, 133	0	1
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
71. 00 07100 AMBULANCE (2)	0. 000000)		0	0	71.00
100.00 Total (Sum of lines 40 - 71)		206, 148		0 192, 229	0	100.00
(1) For title V and XIX use columns 1, 2, and 4 or	I v.					

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

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

Heal th	Health Financial Systems HOUSE OF THE GOOD SHEPHERD In Lieu of Form CMS-2540-10										
APPORT	FIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 4:3					
			Ti tl	e XVIII	Skilled Nursing Facility	PPS					
	Cost Center Description					1. 00					
	PART II - APPORTIONMENT OF VACCINE COST					1.00					
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	et C, column 3	, line 49)	1. 046388	1.00				
2.00	Program vaccine charges (From your reco					0	2.00				
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	oviders, transf	er this amoun	t to Worksheet	0	3. 00				
	E, Part I, line 18)										
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part	Part A					
		(From Wkst. B, Part I,	Allied Health (From Wkst.	Nursing & Allied Health	A Cost (From	Nursing & Allied Health					
		Col. 18	B, Part I,	Costs to	I, Col. 4)	Costs for					
		001. 10	Col. 14)	Total Costs		Pass Through					
			33.1 1.7	Part A (Col.		(Col. 3 x					
				2 / Col. 1)		Col . 4)					
		1. 00	2.00	3.00	4. 00	5. 00					
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH								
	ANCILLARY SERVICE COST CENTERS		,	,							
40.00	04000 RADI OLOGY	13, 087	l .			l e					
41.00	04100 LABORATORY	25, 038	0	0.00000		l	41.00				
42.00	04200 I NTRAVENOUS THERAPY	(050	0	0.00000		0	42. 00 43. 00				
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	6, 858 193, 069	l .	0. 00000 0. 00000		0	44.00				
45.00	04500 OCCUPATI ONAL THERAPY	377, 814		0.00000			45.00				
46. 00	04600 SPEECH PATHOLOGY	54, 688		0.00000		•	46.00				
47. 00	04700 ELECTROCARDI OLOGY	01,000	0	0. 00000		0	47.00				
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	323	Ö	0. 00000		Ō	48.00				
49.00	04900 DRUGS CHARGED TO PATIENTS	67, 762	0	0. 00000	0 25, 133	0	49. 00				
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000	0	0	50.00				
	05100 SUPPORT SURFACES	0	0	0.00000		0					
100.00	Total (Sum of lines 40 - 52)	738, 639	0		192, 229	0	100. 00				

OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315422	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/26/2022 4:3	pared
		Title XVIII	Skilled Nursing Facility	PPS	т рііі
	· · · · · · · · · · · · · · · · · · ·		raciiity		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
00	INPATIENT DAYS Inpatient days including private room days			8, 011	1.0
. 00	Private room days			8,011	
. 00	Inpatient days including private room days applicable to the	Program		802	
. 00	Medically necessary private room days applicable to the Progr			0	4.
. 00	Total general inpatient routine service cost			4, 528, 334	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
. 00	General inpatient routine service charges			3, 492, 851	
. 00	General inpatient routine service cost/charge ratio (Line 5	divided by line 6)		1. 296458	
. 00 . 00	Enter private room charges from your records	no O divided by privete	noom dovo lino	0.00	8. 9.
. 00	Average private room per diem charge (Private room charges li 2)	ne 8 divided by private	room days, rine	0.00	9.
0. 00	Enter semi-private room charges from your records			3, 492, 851	10.
1. 00	Average semi-private room per diem charge (Semi-private room	n charges line 10, divid	ed by	436. 01	11.
	semi -pri vate room days)	3	,		
2. 00	Average per diem private room charge differential (Line 9 mir	•		0. 00 0. 00	
3. 00					
4.00	Private room cost differential adjustment (Line 2 times line			0	
5.00	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS	ost differential (Line 5	minus iine 14)	4, 528, 334	15.
6. 00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		565. 26	16.
7. 00	Program routine service cost (Line 3 times line 16)	,		453, 339	17.
3. 00	Medically necessary private room cost applicable to program			0	
9. 00	Total program general inpatient routine service cost (Line 1			453, 339	
0.00	Capital related cost allocated to inpatient routine service of	costs (From Wkst. B, Pa	rt II column 18,	402, 857	20.
1 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1)			50. 29	21.
2. 00	Program capital related costs (Line 3 times line 21)			40, 333	
3. 00	Inpatient routine service cost (Line 19 minus line 22)			413, 006	
4. 00	Aggregate charges to beneficiaries for excess costs (From pr	rovi der records)		0	1
5. 00	Total program routine service costs for comparison to the cos	st limitation (Line 23 m	inus line 24)	413, 006	25.
6. 00	Enter the per diem limitation (1)				26.
	Inpatient routine service cost limitation (Line 3 times the p				27.
8.00	Reimbursable inpatient routine service costs (Line 22 plus 1		Tine 27)		28.
1) 1;	(Transfer to Worksheet E, Part II, line 4) (See instructions) nes 26 and 27 are not applicable for title XVIII, but may be		+i +l o VI V		l
) LI	les 20 and 27 are not approcable for title xviii, but may be t		title XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COST	S FOR PPS PASS-THROUGH			
. 00	Total SNF inpatient days			8, 011	
. 00	Program inpatient days (see instructions)		VIVA	802	
. 00	Total nursing & allied health costs. (see instructions)(Do no Nursing & allied health ratio. (line 2 divided by line 1)	ot complete for titles V	or XIX)	0. 100112	3. 4.

Health Financial Systems	HOUSE OF THE GOOD	SHEPHERD	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITE	LE XVIII	Provi der No.: 315422	From 01/01/2021	Worksheet E Part I Date/Time Prepared: 5/26/2022 4:31 pm
		Title XVIII	Skilled Nursing	PPS
			l Facility	

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT		1.00	
1. 00	Inpatient PPS amount (See Instructions)	-EWEIVI		489, 806	1. 00
2. 00	Nursing and Allied Health Education Activities (pass through pa	nyments)		0	2. 00
3. 00	Subtotal (Sum of lines 1 and 2)			489, 806	3.00
4. 00	Primary payor amounts			0	4. 00
5.00	Coinsurance			42, 294	5.00
6.00	Allowable bad debts (From your records)			23, 823	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ıcti ons)		19, 775	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	ŕ		15, 485	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			462, 997	11.00
12.00	Interim payments (See instructions)			447, 512	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14.50
14. 55	Demonstration payment adjustment amount after sequestration			0	14.55
14. 75	5 Sequestration for non-claims based amounts (see instructions)				14. 75
14. 99	Sequestration amount (see instructions)			0	14. 99
15. 00				15, 485	15.00
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00				0	17. 00
18. 00				0	18. 00
19. 00				0	19.00
20. 00	1			0	20.00
21. 00	,			0	21.00
22.00	Primary payor amounts			0	22.00
23.00				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	ictions)		0	24. 01
24. 02				0	24. 02
25. 00				0	25.00
26. 00				0	26.00
27. 00 28. 00	Tentative adjustment Other Adjustments (See instructions) Specify			0	27. 00 28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
	Balance due provider/program (see instructions)			0	29. 00
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	0	30.00
55. 55	1. States amounts (Mondiffernation cost report remay in accordance	omo 1 db. 10-2,	23011011 710.2	٥١	55. 66

Title XVIII Skilled Nursing Facility Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1. 00 2.00 3.00 4.00 447, 512 1.00 Total interim payments paid to provider 1.00 2.00 Interim payments payable on individual bills, either 0 2.00 0 submitted or to be submitted to the contractor for services rendered in the cost reporting period. 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 ADJUSTMENTS TO PROVIDER 3.01 0 3.01 3.02 0 0 3.02 0 3.03 0 3.03 3.04 0 0 3.04 0 3.05 0 3.05 Provider to Program 3.50 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 0 3.51 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.99 - 3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 447, 512 0 4.00 (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER O n 5.01 0 5.02 0 5.02 5.03 0 0 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM O n 5 50 5.51 0 0 5.51 0 0 5. 52 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) PROGRAM TO PROVIDER 6.01 15, 485 0 6.01 PROVIDER TO PROGRAM 0 6.02 6.02 0 Total Medicare program liability (see instructions) 462, 997 7.00 0 7.00 Contractor Name Contractor Number

1.00

2.00

8.00

8.00 Name of Contractor

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

Health Financial Systems

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

Provi der No.: 315422

Period: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 4:31 pm

In Lieu of Form CMS-2540-10

oni y)				, 12,01,2021	5/26/2022 4: 3	1 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	T	1.00	2.00	3. 00	4.00	
	Assets CURRENT ASSETS					-
1.00	Cash on hand and in banks	397, 651	0	0	0	1.00
2.00	Temporary investments	0	О	0	0	2.00
3.00	Notes receivable	0	0	0	1	
4.00	Accounts receivable	330, 959		0	0	
5.00	Other receivables	0	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7. 00	Inventory	0	0	0	0	7.00
8. 00	Prepai d expenses	351, 630	0	0	0	
9. 00	Other current assets	424, 659		0	0	
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 504, 899	0	0	0	11.00
	FIXED ASSETS	1				
12.00	Land	328, 328		0		
13.00	Land improvements	2, 281, 301	0	0	-	
14.00	Less: Accumulated depreciation	1/ 10/ /1/	0	0	-	
15. 00 16. 00	Buildings Less Accumulated depreciation	16, 186, 616 -23, 825, 166		0	0 0	
17. 00	Leasehold improvements	-23, 823, 100	0	0	0	
18. 00	Less: Accumulated Amortization	0	0	0	0	
19. 00	Fi xed equipment	10, 091, 698	0	0	0	
20.00	Less: Accumulated depreciation	0	l o	0	0	
21.00	Automobiles and trucks	254, 436	0	0	0	
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Maj or movable equipment	3, 465, 190	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	0	0	0	24.00
25.00	Mi nor equipment - Depreciable	0	0	0	0	
26. 00	Mi nor equipment nondepreciable	0	0	0	0	
27. 00	Other fixed assets	1, 352, 934		0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	10, 135, 337	0	0	0	28. 00
29. 00	OTHER ASSETS Investments		O	0	0	29.00
30.00	Deposits on Leases		0	0		
31. 00	Due from owners/officers	0	0	0	0	
32. 00	Other assets	2, 580, 745	١	0	0	
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	2, 580, 745		0	0	
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	14, 220, 981	0	0		
	Liabilities and Fund Balances				•	
	CURRENT LI ABI LI TI ES		,			
35.00	Accounts payable	1, 428, 324	0	0	-	
36. 00	Salaries, wages, and fees payable	151, 879	1	0		
37. 00	Payrol I taxes payable	-2, 471	0	0	0	
38. 00	Notes & Loans payable (Short term)	775, 000	0	0	0	
39. 00 40. 00	Deferred income	0	U	0	0	39. 00 40. 00
41. 00	Accel erated payments Due to other funds	0	0	0	0	
42. 00	Other current liabilities	34, 072	-	0	l .	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 386, 804		0		
	LONG TERM LIABILITIES		-1	-		
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	7, 829, 461	0	0	0	45.00
46.00	Unsecured Loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	370, 921	0	0	0	
49. 00	OTHER (SPECIFY)	0	0	0		
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	8, 200, 382		0	1	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	10, 587, 186	0	0	0	51.00
E2 00	CAPITAL ACCOUNTS General fund balance	2 422 705			ı	
52. 00 53. 00	Specific purpose fund	3, 633, 795	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		١	^		54.00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			· ·	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
	repracement, and expansion					
59. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	3, 633, 795		0	0	
		3, 633, 795 14, 220, 981		0	0	

Provider No.: 315422 | Period: | Worksheet G-1 | From 01/01/2021 | To 12/03/2021 | To 12/03/20 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 4:3	
		Genera	l Fund	Special P	urpose Fund	Endowment Fund	
		1. 00	2 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) RESTRICTED CONTRIBUTIONS NET FOUNDATION ACTIVITY TRANSFERS Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) NET ASSETS RELEASED FROM RESTRICTIO CHANGES IN NET ASSETS Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	1, 00 411, 266 4, 000, 000 0 0 1, 112, 996 0 0	4, 411, 266 4, 746, 791		4.00 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17.00	sheet (Line 11 - line 18)	Endowment		Fund			17.00
		Fund		I			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) RESTRICTED CONTRIBUTIONS NET FOUNDATION ACTIVITY TRANSFERS	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	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) NET ASSETS RELEASED FROM RESTRICTIO CHANGES IN NET ASSETS	0	000000000000000000000000000000000000000	(0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0			0		18. 00 19. 00

	Financial Systems HENT OF PATIENT REVENUES AND OPERATING EXPENS	HOUSE OF THE GOOD S			Peri od: From 01/01/2021 To 12/31/2021	5/26/2022 4:3	pared:
	Cost Center Description			I npati ent	Outpati ent	Total	
	DADT I DATIENT DEVENUES			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES General Inpatient Routine Care Services						-
1. 00	SKILLED NURSING FACILITY			3, 492, 85	1	3, 492, 851	1.00
2.00	NURSING FACILITY			3, 492, 63		3, 492, 631	2.00
3. 00	ICF/IID					0	3.00
4. 00	OTHER LONG TERM CARE					0	4.00
5. 00	Total general inpatient care services (Sum	of lines 1 - 4)		3, 492, 85	1	3, 492, 851	5.00
3.00	All Other Care Services	01 111103 1 +)		3, 472, 03	'	5, 472, 051	3.00
6.00	ANCI LLARY SERVICES			823, 95	7 0	823, 957	6.00
7. 00	CLINIC			020,70	0	0	1
8. 00	HOME HEALTH AGENCY COST				0	Ō	
9. 00	AMBULANCE				0	Ō	
10.00	RURAL HEALTH CLINIC				0	0	10.00
10. 10	FQHC				0	0	
11. 00	CMHC				0	0	11.00
12.00	HOSPI CE				0 0	0	12.00
13.00	OTHER PATIENT SERVICE REVENUES			6, 570, 79	2 0	6, 570, 792	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13	(Transfer column 3	to	10, 887, 60	0	10, 887, 600	14.00
	Worksheet G-3, Line 1)						
	Cost Center Description						
					1. 00	2. 00	
	PART II - OPERATING EXPENSES						
1.00	Operating Expenses (Per Worksheet A, Col. 3	i, Li ne 100)				12, 054, 603	
2.00	Add (Specify)				0		2.00
3.00					0		3.00
4. 00					0		4.00
5. 00					0		5.00
6. 00					0		6.00
7. 00					0	_	7.00

8.00

9.00

10.00

11.00

12. 00 13. 00 14. 00

0 14.00 12,054,603 15.00

Total Additions (Sum of lines 2 - 7) Deduct (Specify)

14.00 Total Deductions (Sum of lines 9 - 13)
15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

8.00

9.00

10.00

11.00

12.00

	Financial Systems HOUSE OF THE GOOD SHEPHE MENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi	ider No.: 315422	Peri od:	u of Form CMS-2 Worksheet G-3	
STATE	HENT OF PATTENT REVENUES AND OPERATING EXPENSES PROVI	uer No.: 315422	From 01/01/2021	worksneet G-3	
			To 12/31/2021	Date/Time Pre	
			L.	5/26/2022 4: 3	1 pm
				1 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			1. 00	1. 00
2. 00	Less: contractual allowances and discounts on patients accounts			10, 887, 600 2, 257, 260	
3. 00	Net patient revenues (Line 1 minus line 2)			8, 630, 340	
4. 00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)		12, 054, 603	
5. 00	Net income from service to patients (Line 3 minus 4))		-3, 424, 263	
5.00	Other income:			-3, 424, 203	5.00
6. 00	Contributions, donations, bequests, etc			19, 212	6. 00
7. 00	Income from investments			160, 512	
8. 00	Revenues from communications (Telephone and Internet service)			7, 468	
9. 00	Revenue from television and radio service			24, 964	
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	
12.00	Parking Lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			6, 472	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than pat	ients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of skilled nursing space			34, 263	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS			26, 738	24.00
24. 01	MAINTENANCE THERAPY			18, 968	24.01
24. 02	TRANSPORTATION SERVICES			85	24.02
24. 03	ADMI NI STRATI VE SERVI CES			13, 457	24.03
24. 50	COVI D-19 PHE Fundi ng			878, 490	24.50
25.00	Total other income (Sum of lines 6 - 24)			1, 190, 629	25.00
26.00	Total (Line 5 plus line 25)			-2, 233, 634	26.00
27. 00	Other expenses (specify)			0	
28.00				0	28 00

28.00 29. 00 30. 00

0

0 -2, 233, 634 31.00

28.00

29.00

30.00 Total other expenses (Sum of lines 27 - 29)
31.00 Net income (or loss) for the period (Line 26 minus line 30)