

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 12:00 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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 CARE ONE AT NEW MILFORD (315306) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1	1 David Baruch	2 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	David Baruch		2
3	Signatory Title	AUTHORIZED SIGNOR		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	43,973	-1,400	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	43,973	-1,400	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-MEDI-CARE.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 12:00 pm					
1.00		2.00		3.00					
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:									
1.00	Street: 800 RIVER ROAD	PO Box:				1.00			
2.00	City: NEW MILFORD	State: NJ	Zip Code: 07646			2.00			
3.00	County: BERGEN	CBSA Code: 35614	Urban/Rural: U			3.00			
3.01		CBSA Code:				3.01			
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)				
		1.00	2.00	3.00	V	XVIII	XIX		
SNF and SNF-Based Component Identification:									
4.00	SNF	CARE ONE AT NEW MILFORD	315306	05/01/2003	N	P	N	4.00	
5.00	Nursing Facility							5.00	
6.00	ICF/IID							6.00	
7.00	SNF-Based HHA							7.00	
8.00	SNF-Based RHC							8.00	
9.00	SNF-Based FOHC							9.00	
10.00	SNF-Based CMHC							10.00	
11.00	SNF-Based OLTC							11.00	
12.00	SNF-Based HOSPICE							12.00	
13.00	SNF-Based CORF							13.00	
				From:	To:				
				1.00	2.00				
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2023	12/31/2023		14.00		
15.00	Type of Control (See Instructions)				4		15.00		
					Y/N				
					1.00				
Type of Freestanding Skilled Nursing Facility									
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					Y		16.00	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		17.00	
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y		18.00	
Miscellaneous Cost Reporting Information									
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.									
20.00	Straight Line					0		20.00	
21.00	Declining Balance					0		21.00	
22.00	Sum of the Year's Digits					0		22.00	
23.00	Sum of line 20 through 22					0		23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00	
				Part A	Part B	Other			
				1.00	2.00	3.00			
29.00	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.					N	N	N	29.00
30.00	Skilled Nursing Facility								30.00
31.00	Nursing Facility								31.00
32.00	ICF/IID								32.00
33.00	SNF-Based HHA					N	N		33.00
34.00	SNF-Based RHC								34.00
35.00	SNF-Based FOHC								35.00
36.00	SNF-Based CMHC						N		36.00
36.00	SNF-Based OLTC								36.00
				Y/N					
				1.00		2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					N		37.00	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					Y		38.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.					1		39.00	
			Premiums	Paid Losses	Self Insurance				
			1.00	2.00	3.00				
41.00	List malpractice premiums and paid losses:		51,276	0	0		41.00		

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 12:00 pm
				Y/N
				1.00
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N 42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			Y 43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			HB0206 44.00
	1.00	2.00	3.00	
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.				
45.00	Name: HEALTHBRIDGE	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 12001	45.00
46.00	Street: 173 NORTH BRIDGE PLAZA	PO Box:		46.00
47.00	City: FORT LEE	State: NJ	Zip Code: 07024	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/10/2024 12:00 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	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			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	03/19/2024	Y	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	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.	N		N	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:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX REIMBURSEMENT QUESTIONNAIRE

Provider No. : 315306

Period:
 From 01/01/2023
 To 12/31/2023

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/10/2024 12:00 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHARLES	REED	19.00
20.00	Enter the employer/company name of the cost report preparer.	EXECUCARE ASSOCIATES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(609)738-3200	CRWASSC@NETSCAPE.NET	21.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX REIMBURSEMENT QUESTIONNAIRE

Provider No. : 315306

Period:
 From 01/01/2023
 To 12/31/2023

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/10/2024 12:00 pm

		Part B		
		Date		
		4.00		
PS&R Data				
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/19/2024		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.			18.00
			3.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE-PRESIDENT		19.00
20.00	Enter the employer/company name of the cost report preparer.			20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			21.00

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

Provider No. : 315306

Period:
 From 01/01/2023
 To 12/31/2023

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/10/2024 12:00 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	236	86,140	0	7,639	48,115	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	236	86,140	0	7,639	48,115	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	7,292	63,046	0	141	141	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	7,292	63,046	0	141	141	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	138	420	0.00	54.18	341.24	1.00
2.00	NURSING FACILITY	0	0	0.00	0	0	2.00
3.00	ICF/IID	0	0	0.00	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0	0	4.00
5.00	Other Long Term Care	0	0	0.00	0	0	5.00
6.00	SNF-Based CMHC	0	0	0.00	0	0	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	138	420	0.00	54.18	341.24	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX		Other
		16.00	17.00	18.00	19.00		20.00
1.00	SKILLED NURSING FACILITY	150.11	0	127	82	204	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	150.11	0	127	82	204	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	413	183.92	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	413	183.92	0.00	8.00		

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part II
Date/Time Prepared:
5/10/2024 12:00 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	10,995,669	0	10,995,669	382,557.00	28.74 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	10,995,669	0	10,995,669	382,557.00	28.74 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	10,995,669	0	10,995,669	382,557.00	28.74 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	752,148	0	752,148	10,858.00	69.27 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	2,121,441	0	2,121,441		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	2,121,441	0	2,121,441		

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part III
Date/Time Prepared:
5/10/2024 12:00 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (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	0.00	0.00	1.00
2.00	Administrative & General	638,336	0	638,336	15,100.00	2.00
3.00	Plant Operation, Maintenance & Repairs	216,939	0	216,939	9,869.00	3.00
4.00	Laundry & Linen Service	143,967	0	143,967	8,369.00	4.00
5.00	Housekeeping	605,476	0	605,476	35,356.00	5.00
6.00	Dietary	878,724	0	878,724	41,536.00	6.00
7.00	Nursing Administration	902,396	0	902,396	22,823.00	7.00
8.00	Central Services and Supply	41,360	0	41,360	2,158.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	30,867	0	30,867	1,811.00	10.00
11.00	Social Service	148,383	0	148,383	4,375.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	415,937	0	415,937	21,763.00	13.00
14.00	Total (sum lines 1 thru 13)	4,022,385	0	4,022,385	163,160.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/10/2024 12:00 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		58,785	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		849,352	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		2,494	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		276,384	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		796,645	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		137,781	20.00
OTHER				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		2,121,441	24.00
			Amount Reported	
			1.00	
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-3
Part V
Date/Time Prepared:
5/10/2024 12:00 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	875,312	184,587	1,059,899	18,317.00	57.86	1.00
2.00	Licensed Practical Nurses (LPNs)	2,017,446	425,441	2,442,887	50,071.00	48.79	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,802,564	591,007	3,393,571	122,891.00	27.61	3.00
4.00	Total Nursing (sum of lines 1 through 3)	5,695,322	1,201,035	6,896,357	191,279.00	36.05	4.00
5.00	Physical Therapists	424,791	89,580	514,371	11,417.00	45.05	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	602,435	127,042	729,477	14,130.00	51.63	8.00
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	130,175	27,451	157,626	2,570.00	61.33	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	43,363		43,363	438.00	99.00	14.00
15.00	Licensed Practical Nurses (LPNs)	503,530		503,530	6,714.00	75.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	193,315		193,315	3,515.00	55.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	740,208		740,208	10,667.00	69.39	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	7,200		7,200	96.00	75.00	24.00
25.00	Respiratory Therapists	4,740		4,740	95.00	49.89	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-7

Date/Time Prepared:
5/10/2024 12:00 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
16.00		RHC		16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21.00		RMA		21.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00		ES3		24.00
25.00		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		HD1		30.00
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		CE1		44.00
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
53.00		SE3		53.00
54.00		SE2		54.00
55.00		SE1		55.00
56.00		SSC		56.00
57.00		SSB		57.00
58.00		SSA		58.00
59.00		IB2		59.00
60.00		IB1		60.00
61.00		IA2		61.00
62.00		IA1		62.00
63.00		BB2		63.00
64.00		BB1		64.00
65.00		BA2		65.00
66.00		BA1		66.00
67.00		PE2		67.00
68.00		PE1		68.00
69.00		PD2		69.00
70.00		PD1		70.00
71.00		PC2		71.00
72.00		PC1		72.00
73.00		PB2		73.00
74.00		PB1		74.00
75.00		PA2		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-7

Date/Time Prepared:
5/10/2024 12:00 pm

		Group	Days	
76.00		1.00	2.00	
99.00		PA1		76.00
100.00	TOTAL	AAA		99.00
				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	Staffing			101.00
102.00	Recruitment			102.00
103.00	Retention of employees			103.00
104.00	Training			104.00
105.00	OTHER (SPECIFY)			105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)			106.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet A	Date/Time Prepared: 5/10/2024 12:00 pm		
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES		2,008,278	2,008,278	0	2,008,278	1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		5,148	5,148	-238	4,910	2.00
3.00 00300	EMPLOYEE BENEFITS	0	2,318,777	2,318,777	0	2,318,777	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	638,336	3,794,853	4,433,189	0	4,433,189	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	216,939	863,452	1,080,391	0	1,080,391	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	143,967	134,451	278,418	0	278,418	6.00
7.00 00700	HOUSEKEEPING	605,476	133,207	738,683	0	738,683	7.00
8.00 00800	DIETARY	878,724	587,432	1,466,156	0	1,466,156	8.00
9.00 00900	NURSING ADMINISTRATION	902,396	112,489	1,014,885	0	1,014,885	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	41,360	163,623	204,983	-583	204,400	10.00
11.00 01100	PHARMACY	0	38,079	38,079	0	38,079	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	30,867	0	30,867	0	30,867	12.00
13.00 01300	SOCIAL SERVICE	148,383	0	148,383	0	148,383	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	415,937	16,303	432,240	0	432,240	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	5,695,322	827,777	6,523,099	0	6,523,099	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/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	RADIOLOGY	0	55,038	55,038	0	55,038	40.00
41.00 04100	LABORATORY	0	126,680	126,680	0	126,680	41.00
42.00 04200	INTRAVENOUS THERAPY	0	88,111	88,111	0	88,111	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	545,352	42,037	587,389	0	587,389	44.00
45.00 04500	OCCUPATIONAL THERAPY	602,435	0	602,435	0	602,435	45.00
46.00 04600	SPEECH PATHOLOGY	130,175	7,200	137,375	0	137,375	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	583	583	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	318,201	318,201	0	318,201	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	238	238	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	58,345	58,345	0	58,345	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	0	80.00
81.00 08100	INTEREST EXPENSE	0	0	0	0	0	81.00
82.00 08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	10,995,669	11,699,481	22,695,150	0	22,695,150	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	14,819	14,819	0	14,819	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	12,562	12,562	0	12,562	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
100.00	TOTAL	10,995,669	11,726,862	22,722,531	0	22,722,531	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/10/2024 12:00 pm
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Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	619,972	2,628,250	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	4,910	2.00
3.00	00300	EMPLOYEE BENEFITS	0	2,318,777	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-1,279,178	3,154,011	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	1,080,391	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	-1,460	276,958	6.00
7.00	00700	HOUSEKEEPING	0	738,683	7.00
8.00	00800	DIETARY	0	1,466,156	8.00
9.00	00900	NURSING ADMINISTRATION	-4,039	1,010,846	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	204,400	10.00
11.00	01100	PHARMACY	-3,047	35,032	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	30,867	12.00
13.00	01300	SOCIAL SERVICE	0	148,383	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	432,240	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-30,191	6,492,908	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	55,038	40.00
41.00	04100	LABORATORY	0	126,680	41.00
42.00	04200	INTRAVENOUS THERAPY	-7,049	81,062	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	587,389	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	602,435	45.00
46.00	04600	SPEECH PATHOLOGY	0	137,375	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	583	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	-25,456	292,745	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	238	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	52.02
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FQHC	0	0	62.00
63.00	06300	DIALYSIS	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	58,345	71.00
73.00	07300	CMHC	0	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	-730,448	21,964,702	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	14,819	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	12,562	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	95.00
100.00		TOTAL	-730,448	21,992,083	100.00

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/10/2024 12:00 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
	(1) A - RECLASS MED SUPP CHARGED	2.00	3.00	4.00	5.00	
1.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00	0	583	1.00
	(1) C - RECLASS SUPPORT SURFACES					
2.00		SUPPORT SURFACES	51.00	0	238	2.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		0	821	100.00

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

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/10/2024 12:00 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
	(1) A - RECLASS MED SUPP CHARGED	6.00	7.00	8.00	9.00	
1.00		CENTRAL SERVICES & SUPPLY	10.00	0	583	1.00
	(1) C - RECLASS SUPPORT SURFACES					
2.00		CAP REL COSTS - MOVABLE EQUIPMENT	2.00	0	238	2.00
100.00	TOTALS			0	821	100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-7

Date/Time Prepared:
5/10/2024 12:00 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	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	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	0	0	0	0	7.00
8.00	Reconciling Items	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	0	0	0	0	9.00
Description		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	Subtotal (sum of lines 1-6)	0	0			7.00
8.00	Reconciling Items	0	0			8.00
9.00	Total (line 7 minus line 8)	0	0			9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/10/2024 12:00 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line No.
			3.00	4.00
1.00	2.00	3.00	4.00	
1.00 Investment income on restricted funds (chapter 2)	B	-2,935	CAP REL COSTS - BLDGS & FIXTURES	1.00 1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 2.00
3.00 Refunds and rebates of expenses (chapter 8)		0		0.00 3.00
4.00 Rental of provider space by suppliers (chapter 8)		0		0.00 4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 5.00
6.00 Television and radio service (chapter 21)		0		0.00 6.00
7.00 Parking lot (chapter 21)		0		0.00 7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0		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 10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00 11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	271,622		12.00
13.00 Laundry and linen service	B	-1,460	LAUNDRY & LINEN SERVICE	6.00 13.00
14.00 Revenue - Employee meals		0		0.00 14.00
15.00 Cost of meals - Guests		0		0.00 15.00
16.00 Sale of medical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts		0		0.00 18.00
19.00 Vending machines		0		0.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF	82.00 22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES	1.00 23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT	2.00 24.00
25.00 FACILITY MARKETING	A	-6,490	ADMINISTRATIVE & GENERAL	4.00 25.00
25.01 MISCELLANEOUS EXPENSE	A	-285	ADMINISTRATIVE & GENERAL	4.00 25.01
25.02 RESIDENT REPLACEMENT ITEMS	A	-6,278	ADMINISTRATIVE & GENERAL	4.00 25.02
25.03 MARKETING EXPENSE	A	-32,057	ADMINISTRATIVE & GENERAL	4.00 25.03
25.04 MARKETING CORP EXPENSE	A	-11,832	ADMINISTRATIVE & GENERAL	4.00 25.04
25.05 MARKETING - MEALS	A	-12,877	ADMINISTRATIVE & GENERAL	4.00 25.05
25.06 SHOWS & CONFERENCES	A	-165	ADMINISTRATIVE & GENERAL	4.00 25.06
25.07 CHARITABLE CONTRIBUTIONS	A	-99	ADMINISTRATIVE & GENERAL	4.00 25.07
25.08 SPONSORSHIPS	A	-667	ADMINISTRATIVE & GENERAL	4.00 25.08
25.09 BAD DEBT EXPENSE	A	-594,011	ADMINISTRATIVE & GENERAL	4.00 25.09
25.10 BAD DEBT EXPENSE - MEDICARE	A	-205,577	ADMINISTRATIVE & GENERAL	4.00 25.10
25.11 BAD DEBT EXPENSE - OTHER	A	34,000	ADMINISTRATIVE & GENERAL	4.00 25.11
25.12 OTHER MEDICAL SERVICES EXPENSE	A	-30,191	SKILLED NURSING FACILITY	30.00 25.12
25.13 OTHER REVENUE	B	-128,939	ADMINISTRATIVE & GENERAL	4.00 25.13
25.14 OTHER INCOME	B	-2,207	ADMINISTRATIVE & GENERAL	4.00 25.14
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-730,448		100.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-1
Parts I-11
Date/Time Prepared:
5/10/2024 12:00 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT - RELATED PARTY	1.00
2.00	4.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE FEE - RELATED PARTY	2.00
3.00	4.00	ADMINISTRATIVE & GENERAL	IT ALLOCATION - RELATED PARTY	3.00
4.00	4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	4.00
5.00	4.00	ADMINISTRATIVE & GENERAL	REALTY ADMIN	5.00
6.00	9.00	NURSING ADMINISTRATION	PHARMACY CONSULTANT	6.00
7.00	10.00	CENTRAL SERVICES & SUPPLY	WOUND CARE EXPENSE	7.00
8.00	11.00	PHARMACY	DRUGS-NON-PRESCRIPTION, NON-LEGEND	8.00
9.00	11.00	PHARMACY	PHARMACY SUPPLIES	9.00
9.01	42.00	INTRAVENOUS THERAPY	IV EXPENSE	9.01
9.02	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND	9.02
9.03	49.00	DRUGS CHARGED TO PATIENTS	DRUGS OTH	9.03
9.04	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN DRUGS-PRESCRIPTION, MEDICARE A	9.04
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00
	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
	4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	2,173,198	1,550,291	622,907	1.00
2.00	0	160,852	-160,852	2.00
3.00	0	8,283	-8,283	3.00
4.00	1,006,304	1,149,322	-143,018	4.00
5.00	459	0	459	5.00
6.00	46,450	50,489	-4,039	6.00
7.00	21,840	21,840	0	7.00
8.00	32,769	35,619	-2,850	8.00
9.00	2,263	2,460	-197	9.00
9.01	81,062	88,111	-7,049	9.01
9.02	46,429	50,466	-4,037	9.02
9.03	103,098	112,063	-8,965	9.03
9.04	143,218	155,672	-12,454	9.04
10.00	3,657,090	3,385,468	271,622	10.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-II Date/Time Prepared: 5/10/2024 12:00 pm
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Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	A	DANIEL STRAUS	70.00	1.00
2.00	A	MOSHAEL STRAUS	4.00	2.00
3.00	A	DES 2009 FAMILY TRUST	24.00	3.00
4.00	A	LJJ INVESTMENTS	1.00	4.00
5.00	A	1997 TRUST REMAINDER	1.00	5.00
6.00	A	DANIEL STRAUS	70.00	6.00
7.00	A	DANIEL STRAUS	70.00	7.00
8.00	F	DES HOLDING CO. INC.	0.00	8.00
9.00	F	PARTNERS PHARMACY SERVICES LLC	0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

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

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

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

1.00		THCI OF NEW JERSEY LLC	70.00	REALTY	1.00
2.00		THCI OF NEW JERSEY LLC	4.00	REALTY	2.00
3.00		THCI OF NEW JERSEY LLC	24.00	REALTY	3.00
4.00		THCI OF NEW JERSEY LLC	1.00	REALTY	4.00
5.00		THCI OF NEW JERSEY LLC	1.00	REALTY	5.00
6.00		HEALTHBRIDGE MANAGEMENT LLC	100.00	MANAGEMENT	6.00
7.00		TOTALCARE LLC	99.00	WOUND CARE	7.00
8.00		TOTALCARE LLC	1.00	WOUND CARE	8.00
9.00		PARTNERS PHARMACY LLC	100.00	PHARMACY	9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal		
		BLDGS & FIXTURES	MOVABLE EQUIPMENT				
		0	1.00				2.00
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	2,628,250	2,628,250			1.00	
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	4,910		4,910		2.00	
3.00 00300	EMPLOYEE BENEFITS	2,318,777	41,708	78	2,360,563	3.00	
4.00 00400	ADMINISTRATIVE & GENERAL	3,154,011	65,497	122	137,039	4.00	
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,080,391	91,885	172	46,573	1,219,021	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	276,958	59,693	112	30,907	367,670	6.00
7.00 00700	HOUSEKEEPING	738,683	27,805	52	129,984	896,524	7.00
8.00 00800	DIETARY	1,466,156	281,053	525	188,645	1,936,379	8.00
9.00 00900	NURSING ADMINISTRATION	1,010,846	177,291	331	193,727	1,382,195	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	204,400	18,492	35	8,879	231,806	10.00
11.00 01100	PHARMACY	35,032	0	0	0	35,032	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	30,867	8,436	16	6,627	45,946	12.00
13.00 01300	SOCIAL SERVICE	148,383	133,761	250	31,855	314,249	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	432,240	0	0	89,294	521,534	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	6,492,908	1,666,479	3,112	1,222,679	9,385,178	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/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	RADIOLOGY	55,038	0	0	0	55,038	40.00
41.00 04100	LABORATORY	126,680	0	0	0	126,680	41.00
42.00 04200	INTRAVENOUS THERAPY	81,062	0	0	0	81,062	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	587,389	36,477	68	117,077	741,011	44.00
45.00 04500	OCCUPATIONAL THERAPY	602,435	11,068	21	129,331	742,855	45.00
46.00 04600	SPEECH PATHOLOGY	137,375	2,160	4	27,946	167,485	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	583	0	0	0	583	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	292,745	0	0	0	292,745	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	238	0	0	0	238	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	58,345	0	0	0	58,345	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW - SNF						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	21,964,702	2,621,805	4,898	2,360,563	21,958,245	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	14,819	0	0	0	14,819	90.00
91.00 09100	BARBER AND BEAUTY SHOP	12,562	6,445	12	0	19,019	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	99.00
100.00	TOTAL	21,992,083	2,628,250	4,910	2,360,563	21,992,083	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		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	ADMINISTRATIVE & GENERAL	3,356,669				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	219,574	1,438,595			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	66,226	35,351	469,247		6.00	
7.00	00700	HOUSEKEEPING	161,485	16,467	0	1,074,476	7.00	
8.00	00800	DIETARY	348,786	166,445	0	128,962	2,580,572	8.00
9.00	00900	NURSING ADMINISTRATION	248,965	104,995	0	81,350	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	41,754	10,951	0	8,485	0	10.00
11.00	01100	PHARMACY	6,310	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	8,276	4,996	0	3,871	0	12.00
13.00	01300	SOCIAL SERVICE	56,603	79,216	0	61,377	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	93,940	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,690,489	986,920	469,247	764,666	2,580,572	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/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	RADIOLOGY	9,914	0	0	0	0	40.00
41.00	04100	LABORATORY	22,818	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	14,601	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	133,473	21,603	0	16,738	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	133,805	6,555	0	5,079	0	45.00
46.00	04600	SPEECH PATHOLOGY	30,168	1,279	0	991	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	105	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	52,730	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	43	0	0	0	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FQHC	0	0	0	0	0	62.00
63.00	06300	DIALYSIS	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	10,509	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	3,350,574	1,434,778	469,247	1,071,519	2,580,572	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	2,669	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	3,426	3,817	0	2,957	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	3,356,669	1,438,595	469,247	1,074,476	2,580,572	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	1,817,505					9.00
10.00	01000	0	292,996				10.00
11.00	01100	0	0	41,342			11.00
12.00	01200	0	0	0	63,089		12.00
13.00	01300	0	0	0	0	511,445	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,817,505	292,996	41,342	63,089	511,445	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		1,817,505	292,996	41,342	63,089	511,445	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		1,817,505	292,996	41,342	63,089	511,445	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	615,474			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	615,474	19,218,923	0	19,218,923 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	64,952	0	64,952 40.00
41.00 04100	LABORATORY	0	0	149,498	0	149,498 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	95,663	0	95,663 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	912,825	0	912,825 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	888,294	0	888,294 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	199,923	0	199,923 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	688	0	688 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	345,475	0	345,475 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	281	0	281 51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	68,854	0	68,854 71.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	615,474	21,945,376	0	21,945,376 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	17,488	0	17,488 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	29,219	0	29,219 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	0	615,474	21,992,083	0	21,992,083 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	41,708	78	41,786	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	65,497	122	65,619	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	91,885	172	92,057	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	59,693	112	59,805	6.00
7.00 00700	HOUSEKEEPING	0	27,805	52	27,857	7.00
8.00 00800	DIETARY	0	281,053	525	281,578	8.00
9.00 00900	NURSING ADMINISTRATION	0	177,291	331	177,622	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	18,492	35	18,527	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	8,436	16	8,452	12.00
13.00 01300	SOCIAL SERVICE	0	133,761	250	134,011	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	1,666,479	3,112	1,669,591	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	36,477	68	36,545	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	11,068	21	11,089	45.00
46.00 04600	SPEECH PATHOLOGY	0	2,160	4	2,164	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	2,621,805	4,898	2,626,703	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	6,445	12	6,457	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	2,628,250	4,910	2,633,160	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400	68,045					4.00
5.00	00500	4,451	97,332				5.00
6.00	00600	1,342	2,392	64,086			6.00
7.00	00700	3,273	1,114	0	34,545		7.00
8.00	00800	7,070	11,261	0	4,146	307,394	8.00
9.00	00900	5,046	7,104	0	2,615	0	9.00
10.00	01000	846	741	0	273	0	10.00
11.00	01100	128	0	0	0	0	11.00
12.00	01200	168	338	0	124	0	12.00
13.00	01300	1,147	5,360	0	1,973	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	1,904	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	34,274	66,772	64,086	24,586	307,394	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	201	0	0	0	0	40.00
41.00	04100	463	0	0	0	0	41.00
42.00	04200	296	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	2,705	1,462	0	538	0	44.00
45.00	04500	2,712	443	0	163	0	45.00
46.00	04600	611	87	0	32	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	2	0	0	0	0	48.00
49.00	04900	1,069	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	1	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	213	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		67,922	97,074	64,086	34,450	307,394	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	54	0	0	0	0	90.00
91.00	09100	69	258	0	95	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00		0	0	0	0	0	99.00
100.00		68,045	97,332	64,086	34,545	307,394	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	195,816					9.00
10.00	01000		20,544				10.00
11.00	01100			128			11.00
12.00	01200				9,199		12.00
13.00	01300					143,055	13.00
14.00	01400						14.00
15.00	01500						15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	195,816	20,544	128	9,199	143,055	30.00
31.00	03100						31.00
32.00	03200						32.00
33.00	03300						33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000						40.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
44.00	04400						44.00
45.00	04500						45.00
46.00	04600						46.00
47.00	04700						47.00
48.00	04800						48.00
49.00	04900						49.00
50.00	05000						50.00
51.00	05100						51.00
52.00	05200						52.00
52.01	05201						52.01
52.02	05202						52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000						60.00
61.00	06100						61.00
62.00	06200						62.00
63.00	06300						63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000						70.00
71.00	07100						71.00
73.00	07300						73.00
74.00	07400						74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300						83.00
84.00	08400						84.00
84.01	08401						84.01
89.00		195,816	20,544	128	9,199	143,055	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
93.00	09300						93.00
94.00	09400						94.00
95.00	09500						95.00
98.00							98.00
99.00							99.00
100.00		195,816	20,544	128	9,199	143,055	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	3,485			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	3,485	2,560,575	0	2,560,575
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	201	0	201
41.00 04100	LABORATORY	0	0	463	0	463
42.00 04200	INTRAVENOUS THERAPY	0	0	296	0	296
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	43,322	0	43,322
45.00 04500	OCCUPATIONAL THERAPY	0	0	16,696	0	16,696
46.00 04600	SPEECH PATHOLOGY	0	0	3,389	0	3,389
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2	0	2
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	1,069	0	1,069
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	1	0	1
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC					62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	213	0	213
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	3,485	2,626,227	0	2,626,227
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	54	0	54
91.00 09100	BARBER AND BEAUTY SHOP	0	0	6,879	0	6,879
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	0	3,485	2,633,160	0	2,633,160

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	77,888					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		77,888				2.00
3.00 00300	EMPLOYEE BENEFITS	1,236	1,236	10,995,669			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,941	1,941	638,336	-3,356,669	18,635,414	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	2,723	2,723	216,939	0	1,219,021	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,769	1,769	143,967	0	367,670	6.00
7.00 00700	HOUSEKEEPING	824	824	605,476	0	896,524	7.00
8.00 00800	DIETARY	8,329	8,329	878,724	0	1,936,379	8.00
9.00 00900	NURSING ADMINISTRATION	5,254	5,254	902,396	0	1,382,195	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	548	548	41,360	0	231,806	10.00
11.00 01100	PHARMACY	0	0	0	0	35,032	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	250	250	30,867	0	45,946	12.00
13.00 01300	SOCIAL SERVICE	3,964	3,964	148,383	0	314,249	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	0	0	415,937	0	521,534	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	49,386	49,386	5,695,322	0	9,385,178	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/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	RADIOLOGY	0	0	0	0	55,038	40.00
41.00 04100	LABORATORY	0	0	0	0	126,680	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	81,062	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	1,081	1,081	545,352	0	741,011	44.00
45.00 04500	OCCUPATIONAL THERAPY	328	328	602,435	0	742,855	45.00
46.00 04600	SPEECH PATHOLOGY	64	64	130,175	0	167,485	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	583	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	292,745	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	238	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	58,345	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW - SNF						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	77,697	77,697	10,995,669	-3,356,669	18,601,576	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	14,819	90.00
91.00 09100	BARBER AND BEAUTY SHOP	191	191	0	0	19,019	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2,628,250	4,910	2,360,563		3,356,669	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	33.743966	0.063039	0.214681		0.180123	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			41,786		68,045	104.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
105.00 Unit cost multiplier (Wkst. B, Part 11)			0.003800	4A	0.003651	105.00	

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	71,988					6.00
7.00	00700	1,769	63,046				7.00
8.00	00800	824	0	69,395			8.00
9.00	00900	8,329	0	8,329	189,138		9.00
10.00	01000	5,254	0	5,254	0	63,046	10.00
11.00	01100	548	0	548	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	250	0	250	0	0	13.00
14.00	01400	3,964	0	3,964	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	49,386	63,046	49,386	189,138	63,046	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,081	0	1,081	0	0	44.00
45.00	04500	328	0	328	0	0	45.00
46.00	04600	64	0	64	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		71,797	63,046	69,204	189,138	63,046	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	191	0	191	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00		1,438,595	469,247	1,074,476	2,580,572	1,817,505	102.00
103.00		19,983,817	7,442,931	15,483,479	13,643,858	28,828,237	103.00
104.00		97,332	64,086	34,545	307,394	195,816	104.00
105.00		1,352,059	1,016,496	0,497,802	1,625,237	3,105,923	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	63,046					10.00
11.00	01100	0	63,046				11.00
12.00	01200	0	0	63,046			12.00
13.00	01300	0	0	0	63,046		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	63,046	63,046	63,046	63,046	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		63,046	63,046	63,046	63,046	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00		292,996	41,342	63,089	511,445	0	102.00
103.00		4.647337	0.655743	1.000682	8.112251	0.000000	103.00
104.00		20,544	128	9,199	143,055	0	104.00
105.00		0.325857	0.002030	0.145909	2.269058	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		OTHER GENERAL SERVICE		
		ACTIVITIES (PATIENT DAYS)		
		15.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500	ACTIVITIES	63,046	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	63,046	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF/IID	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	40.00
41.00	04100	LABORATORY	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100	SUPPORT SURFACES	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	52.01
52.02	05202	MEDICAL SERVICES	0	52.02
OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FQHC	0	62.00
63.00	06300	DIALYSIS	0	63.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
73.00	07300	CMHC	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	74.00
SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	63,046	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	95.00
98.00		Cross Foot Adjustments		98.00
99.00		Negative Cost Centers		99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	615,474	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	9.762301	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	3,485	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.055277	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/10/2024 12:00 pm		
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)		
		1.00	2.00	3.00		
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	64,952	137,595	0.472052	40.00
41.00	04100	LABORATORY	149,498	316,700	0.472049	41.00
42.00	04200	INTRAVENOUS THERAPY	95,663	220,277	0.434285	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	912,825	2,003,887	0.455527	44.00
45.00	04500	OCCUPATIONAL THERAPY	888,294	2,880,917	0.308337	45.00
46.00	04600	SPEECH PATHOLOGY	199,923	618,966	0.322995	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	688	1,457	0.472203	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	345,475	795,503	0.434285	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	281	594	0.473064	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0.000000	52.01
52.02	05202	MEDICAL SERVICES	0	0	0.000000	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FOHC				62.00
63.00	06300	DIALYSIS	0	0	0.000000	63.00
71.00	07100	AMBULANCE	68,854	145,862	0.472049	71.00
100.00		Total	2,726,453	7,121,758		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/10/2024 12:00 pm
		Title XVIII (1)	Skilled Nursing Facility	PPS

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
			1.00	2.00	3.00	4.00		5.00
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0.472052	13,844	0	6,535	0	40.00
41.00	04100	LABORATORY	0.472049	19,886	0	9,387	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.434285	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.455527	780,261	0	355,430	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.308337	1,039,191	0	320,421	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.322995	300,897	0	97,188	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.472203	1,457	0	688	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0.434285	92,464	0	40,156	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0.473064	594	0	281	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0.000000	0	0	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0.000000	0	0	0	0	52.01
52.02	05202	MEDICAL SERVICES	0.000000	0	0	0	0	52.02
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	FOHC						62.00
63.00	06300	DIALYSIS	0.000000	0	0	0	0	63.00
71.00	07100	AMBULANCE (2)	0.472049		0			71.00
100.00		Total (Sum of lines 40 - 71)		2,248,594	0	830,086	0	100.00

(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.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/10/2024 12:00 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST					
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		0.434285	1.00
2.00		Program vaccine charges (From your records, or the PS&R)		4,525	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		1,965	3.00

Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)
		1.00	2.00	3.00	4.00	5.00

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	64,952	0	0.000000	6,535	0	40.00
41.00	04100	LABORATORY	149,498	0	0.000000	9,387	0	41.00
42.00	04200	INTRAVENOUS THERAPY	95,663	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	912,825	0	0.000000	355,430	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	888,294	0	0.000000	320,421	0	45.00
46.00	04600	SPEECH PATHOLOGY	199,923	0	0.000000	97,188	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	688	0	0.000000	688	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	345,475	0	0.000000	40,156	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	281	0	0.000000	281	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0.000000	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	0.000000	0	0	52.02
100.00		Total (Sum of lines 40 - 52)	2,657,599	0		830,086	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/10/2024 12:00 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		63,046	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		7,639	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		19,218,923	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		25,488,953	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.754010	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		19,218,923	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		304.84	16.00
17.00	Program routine service cost (Line 3 times line 16)		2,328,673	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		2,328,673	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		2,560,575	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		40.61	21.00
22.00	Program capital related cost (Line 3 times line 21)		310,220	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		2,018,453	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		2,018,453	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		63,046	1.00
2.00	Program inpatient days (see instructions)		7,639	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)		0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)		0.121165	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-III Date/Time Prepared: 5/10/2024 12:00 pm
	Title XIX	Skilled Nursing Facility	

	1.00	
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PART I CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1.00	Inpatient days including private room days	63,046	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	48,115	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	19,218,923	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	25,488,953	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.754010	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	19,218,923	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	304.84	16.00
17.00	Program routine service cost (Line 3 times line 16)	14,667,377	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	14,667,377	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	2,560,575	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	40.61	21.00
22.00	Program capital related cost (Line 3 times line 21)	1,953,950	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	12,713,427	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	12,713,427	25.00
26.00	Enter the per diem limitation (1)	0.00	26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	0	27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)	14,667,377	28.00

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

	1.00	
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PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days	63,046	1.00
2.00	Program inpatient days (see instructions)	48,115	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.763173	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 12:00 pm
		Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		6,804,413	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		6,804,413	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		1,102,200	5.00
6.00	Allowable bad debts (From your records)		555,614	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		404,415	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		361,149	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)		6,063,362	11.00
12.00	Interim payments (See instructions)		5,891,108	12.00
13.00	Tentative 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		7,014	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		7,223	14.75
14.99	Sequestration amount (see instructions)		114,044	14.99
15.00	Balance due provider/program (see Instructions)		43,973	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		1,965	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		1,965	19.00
20.00	Medicare Part B ancillary charges (See instructions)		4,525	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		1,965	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		1,965	25.00
26.00	Interim payments (See instructions)		3,326	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		39	28.99
29.00	Balance due provider/program (see instructions)		-1,400	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315306	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/10/2024 12:00 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		5,581,155		3,326
			309,953		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		5,891,108		3,326
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	PROGRAM TO PROVIDER		43,973		0
6.02	PROVIDER TO PROGRAM		0		1,400
7.00	Total Medicare program liability (see instructions)		5,935,081		1,926
			Contractor Name		Contractor Number
			1.00	2.00	
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.

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

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet G

Date/Time Prepared:
5/10/2024 12:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	65,005	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,218,544	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-70,469	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	44,192	0	0	0	8.00
9.00	Other current assets	85,533	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2,342,805	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	10,291	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	10,291	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	2,353,096	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,397,084	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,230,915	0	0	0	36.00
37.00	Payroll taxes payable	-10,067	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	85,533	0	0	0	41.00
42.00	Other current liabilities	1,362,545	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4,066,010	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	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	-4,123,523	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	-4,123,523	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-57,513	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,410,609	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	2,410,609	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	2,353,096	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-1

Date/Time Prepared:
5/10/2024 12:00 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		1,961,755		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		448,859			2.00
3.00	Total (sum of line 1 and line 2)		2,410,614		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		2,410,614		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00	ROUNDING	5		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		5		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		2,410,609		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)					4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 5 - 9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)					12.00
13.00	ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/10/2024 12:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	25,488,953		25,488,953	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	25,488,953		25,488,953	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	7,121,758	0	7,121,758	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	32,610,711	0	32,610,711	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			22,722,531	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			22,722,531	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315306

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-3

Date/Time Prepared:
5/10/2024 12:00 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	32,610,711	1.00
2.00	Less: contractual allowances and discounts on patients accounts	9,579,922	2.00
3.00	Net patient revenues (Line 1 minus line 2)	23,030,789	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	22,722,531	4.00
5.00	Net income from service to patients (Line 3 minus 4)	308,258	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,935	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	1,460	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	BARBER AND BEAUTY	5,060	24.00
24.01	OTHER REVENUE	128,939	24.01
24.02	OTHER INCOME	2,207	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	140,601	25.00
26.00	Total (Line 5 plus line 25)	448,859	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	448,859	31.00