

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: 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/15/2024 12:23 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.	Date: 5/15/2024 Time: 12:23 pm
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 WAYNE ( 315477 ) 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	<div>1</div> <div>David Baruch</div>	<div>2</div> <div>Y</div>	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	Title XVIII		Title XIX	
			Part A	Part B		
		1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY						
1.00	SKILLED NURSING FACILITY	0	-94,415	0	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	-94,415	0	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider No. : 315477		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/15/2024 12:23 pm		
1.00		2.00		3.00						
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:										
1.00	Street: 493 BLACK OAK RIDGE ROAD		PO Box:						1.00	
2.00	City: WAYNE		State: NJ		Zip Code: 07470				2.00	
3.00	County: PASSAIC		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)			
							V	XVIII	XIX	
			1.00		2.00	3.00	4.00	5.00	6.00	
SNF and SNF-Based Component Identification:										
4.00	SNF		CARE ONE AT WAYNE		315477	08/15/2002	N	P	N	
5.00	Nursing Facility									
6.00	ICF/IID									
7.00	SNF-Based HHA									
8.00	SNF-Based RHC									
9.00	SNF-Based FQHC									
10.00	SNF-Based CMHC									
11.00	SNF-Based OLTC									
12.00	SNF-Based HOSPICE									
13.00	SNF-Based CORF									
						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	
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.										
29.00	Skilled Nursing Facility							N	N	N
30.00	Nursing Facility									
31.00	ICF/IID									
32.00	SNF-Based HHA							N	N	
33.00	SNF-Based RHC									
34.00	SNF-Based FQHC									
35.00	SNF-Based CMHC								N	
36.00	SNF-Based OLTC									
						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:					33,037	0	0	41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/15/2024 12:23 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 BRIDGE PLAZA NORTH	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. : 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/15/2024 12:23 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. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet S-2  
Part II  
Date/Time Prepared:  
5/15/2024 12:23 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. : 315477

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/15/2024 12:23 pm

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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	
<b>Cost Report Preparer Contact Information</b>			
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. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet S-3  
Part I  
Date/Time Prepared:  
5/15/2024 12:23 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	73	26,645	0	12,544	0	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	59	21,535				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	132	48,180	0	12,544	0	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	11,710	24,254	0	524	0	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST	0	0				4.00
5.00	Other Long Term Care	2,718	2,718				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	14,428	26,972	0	524	0	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	514	1,038	0.00	23.94	0.00	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	7	7				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	521	1,045	0.00	23.94	0.00	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	23.37	0	584	0	462	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	388.29				10	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	25.81	0	584	0	472	8.00
Component		Admissions		Full Time Equivalent			
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	1,046	109.10	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		0.00	0.00			4.00
5.00	Other Long Term Care	10	3.17	0.00			5.00
6.00	SNF-Based CMHC		0.00	0.00			6.00
7.00	HOSPICE	0	0.00	0.00			7.00
8.00	Total (Sum of lines 1-7)	1,056	112.27	0.00			8.00

## SNF WAGE INDEX INFORMATION

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet S-3  
Part II  
Date/Time Prepared:  
5/15/2024 12:23 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	
<b>PART II - DIRECT SALARIES</b>						
<b>SALARIES</b>						
1.00	Total salaries (See Instructions)	7,428,376	0	7,428,376	233,514.00	31.81
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	7,428,376	0	7,428,376	233,514.00	31.81
7.00	Other Long Term Care	0	179,618	179,618	6,598.00	27.22
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00
9.00	CMHC	0	0	0	0.00	0.00
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	179,618	179,618	6,598.00	27.22
13.00	Total Adjusted Salaries (line 6 minus line 12)	7,428,376	-179,618	7,248,758	226,916.00	31.94
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	20,818	0	20,818	378.00	55.07
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	1,145,694	0	1,145,694		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	27,703	0	27,703		
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)	1,117,991	0	1,117,991		



## SNF WAGE INDEX INFORMATION

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet S-3  
Part III  
Date/Time Prepared:  
5/15/2024 12:23 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	0.00	0.00	1.00
2.00 Administrative & General	627,318	0	627,318	14,979.00	41.88	2.00
3.00 Plant Operation, Maintenance & Repairs	43,975	0	43,975	2,503.00	17.57	3.00
4.00 Laundry & Linen Service	25,739	0	25,739	2,062.00	12.48	4.00
5.00 Housekeeping	348,735	0	348,735	20,821.00	16.75	5.00
6.00 Dietary	505,987	0	505,987	21,427.00	23.61	6.00
7.00 Nursing Administration	517,969	0	517,969	12,106.00	42.79	7.00
8.00 Central Services and Supply	30,472	0	30,472	1,924.00	15.84	8.00
9.00 Pharmacy	0	0	0	0.00	0.00	9.00
10.00 Medical Records & Medical Records Library	47,533	0	47,533	1,975.00	24.07	10.00
11.00 Social Service	154,199	0	154,199	4,020.00	38.36	11.00
12.00 Nursing and Allied Health Ed. Act.						12.00
13.00 Other General Service	202,643	0	202,643	10,470.00	19.35	13.00
14.00 Total (sum lines 1 thru 13)	2,504,570	0	2,504,570	92,287.00	27.14	14.00

## SNF WAGE RELATED COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet S-3  
Part IV  
Date/Time Prepared:  
5/15/2024 12:23 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	33,732	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)	456,732	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)	1,316	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	115,944	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	457,102	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	77,711	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	3,157	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1,145,694	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. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet S-3  
Part V  
Date/Time Prepared:  
5/15/2024 12:23 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	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	958,428	117,538	1,075,966	20,695.00	51.99	1.00
2.00	Licensed Practical Nurses (LPNs)	913,196	111,991	1,025,187	26,897.00	38.12	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,374,817	168,602	1,543,419	49,911.00	30.92	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,246,441	398,131	3,644,572	97,503.00	37.38	4.00
5.00	Physical Therapists	824,005	101,053	925,058	19,933.00	46.41	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	632,271	77,539	709,810	14,571.00	48.71	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	109,057	13,374	122,431	2,620.00	46.73	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
<b>Contract Labor</b>							
<b>Nursing Occupations</b>							
14.00	Registered Nurses (RNs)	8,213		8,213	111.00	73.99	14.00
15.00	Licensed Practical Nurses (LPNs)	0		0	0.00	0.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,876		1,876	52.00	36.08	16.00
17.00	Total Nursing (sum of lines 14 through 16)	10,089		10,089	163.00	61.90	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	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	10,729		10,729	215.00	49.90	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315477

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

Worksheet S-7

Date/Time Prepared:  
5/15/2024 12:23 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. : 315477

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

Worksheet S-7

Date/Time Prepared:  
5/15/2024 12:23 pm

		Group	Days	
		1.00	2.00	
76.00		PA1		76.00
99.00		AAA		99.00
100.00	TOTAL			100.00
		Expenses	Percentage	Y/N
		1.00	2.00	3.00
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)				
101.00	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. : 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/15/2024 12:23 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification 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		4,140,461	4,140,461	0	4,140,461	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		68,888	68,888	-20,923	47,965	2.00
3.00	00300	EMPLOYEE BENEFITS	0	910,986	910,986	0	910,986	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	627,318	1,941,164	2,568,482	0	2,568,482	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	43,975	503,321	547,296	0	547,296	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	25,739	41,778	67,517	0	67,517	6.00
7.00	00700	HOUSEKEEPING	348,735	41,354	390,089	0	390,089	7.00
8.00	00800	DIETARY	505,987	299,628	805,615	0	805,615	8.00
9.00	00900	NURSING ADMINISTRATION	517,969	25,007	542,976	0	542,976	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	30,472	208,726	239,198	-14,897	224,301	10.00
11.00	01100	PHARMACY	0	15,349	15,349	0	15,349	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	47,533	0	47,533	0	47,533	12.00
13.00	01300	SOCIAL SERVICE	154,199	0	154,199	0	154,199	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	202,643	10,709	213,352	0	213,352	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	3,246,441	61,596	3,308,037	-179,618	3,128,419	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	179,618	179,618	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	64,728	64,728	0	64,728	40.00
41.00	04100	LABORATORY	0	102,476	102,476	0	102,476	41.00
42.00	04200	INTRAVENOUS THERAPY	0	410,701	410,701	0	410,701	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	936,037	18,924	954,961	0	954,961	44.00
45.00	04500	OCCUPATIONAL THERAPY	632,271	0	632,271	0	632,271	45.00
46.00	04600	SPEECH PATHOLOGY	109,057	0	109,057	0	109,057	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,897	14,897	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	714,473	714,473	0	714,473	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	20,923	20,923	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	64,737	64,737	0	64,737	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)	7,428,376	9,645,006	17,073,382	0	17,073,382	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	11,658	11,658	0	11,658	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	9,184	9,184	0	9,184	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	7,428,376	9,665,848	17,094,224	0	17,094,224	100.00

## RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315477

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

Worksheet A

Date/Time Prepared:  
5/15/2024 12:23 pm

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	-66,544	4,073,917	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	47,965	2.00
3.00	00300	EMPLOYEE BENEFITS	0	910,986	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-675,857	1,892,625	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	547,296	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	67,517	6.00
7.00	00700	HOUSEKEEPING	0	390,089	7.00
8.00	00800	DIETARY	0	805,615	8.00
9.00	00900	NURSING ADMINISTRATION	-2,361	540,615	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	224,301	10.00
11.00	01100	PHARMACY	-1,228	14,121	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	47,533	12.00
13.00	01300	SOCIAL SERVICE	0	154,199	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	213,352	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-25,170	3,103,249	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	179,618	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	64,728	40.00
41.00	04100	LABORATORY	0	102,476	41.00
42.00	04200	INTRAVENOUS THERAPY	-32,856	377,845	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	954,961	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	632,271	45.00
46.00	04600	SPEECH PATHOLOGY	0	109,057	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,897	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	-57,157	657,316	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	20,923	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	64,737	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)	-861,173	16,212,209	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	11,658	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	9,184	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	-861,173	16,233,051	100.00

## RECLASSIFICATIONS

Provider No. : 315477

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

Worksheet A-6

Date/Time Prepared:  
5/15/2024 12:23 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
	(1) A - RECLASS MED SUPP					
1.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00	0	14,897	1.00
	(1) C - RECLASS SUPP SURFACE					
2.00		SUPPORT SURFACES	51.00	0	20,923	2.00
	(1) E - RECLASS ALF RNS					
3.00		OTHER LONG TERM CARE	33.00	25,245	0	3.00
4.00		OTHER LONG TERM CARE	33.00	18,004	0	4.00
5.00		OTHER LONG TERM CARE	33.00	136,369	0	5.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		179,618	35,820	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.



## RECLASSIFICATIONS

Provider No. : 315477

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

Worksheet A-6

Date/Time Prepared:  
5/15/2024 12:23 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	(1) A - RECLASS MED SUPP					
1.00		CENTRAL SERVICES & SUPPLY	10.00	0	14,897	1.00
	(1) C - RECLASS SUPP SURFACE					
2.00		CAP REL COSTS - MOVABLE EQUIPMENT	2.00	0	20,923	2.00
	(1) E - RECLASS ALF RNS					
3.00		SKILLED NURSING FACILITY	30.00	25,245	0	3.00
4.00		SKILLED NURSING FACILITY	30.00	18,004	0	4.00
5.00		SKILLED NURSING FACILITY	30.00	136,369	0	5.00
	TOTALS					
100.00				179,618	35,820	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. : 315477

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

Worksheet A-7

Date/Time Prepared:  
5/15/2024 12:23 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	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	0	0	0	0	0	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	0	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. : 315477

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

Worksheet A-8

Date/Time Prepared:  
5/15/2024 12:23 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.	
		1.00	2.00	3.00	4.00	
1.00	Investment income on restricted funds (chapter 2)	B	-2,095	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	-431,884			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals	B	0	ODI ETARY	8.00	14.00
15.00	Cost of meals - Guests	B	0	ODI ETARY	8.00	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)		0	OUTILIZATION REVIEW - SNF	82.00	22.00
23.00	Depreciation--buildings and fixtures		0	OCAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00	Depreciation--movable equipment		0	OCAP REL COSTS - MOVABLE EQUIPMENT	2.00	24.00
25.00	RESIDENT REPLACEMENT ITEMS	A	7,200	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01	REFERAL FEES	A	-10,816	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02	MARKETING EXPENSE	A	-26,393	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03	MARKETING CORP EXPENSE	A	12,540	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04	MARKETING - MEALS	A	-13,457	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05	SHOWS & CONFERENCES	A	-1,048	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06	SPONSORSHIPS	A	-2,252	ADMINISTRATIVE & GENERAL	4.00	25.06
25.07	BAD DEBT EXPENSE	A	-308,687	ADMINISTRATIVE & GENERAL	4.00	25.07
25.08	BAD DEBT EXPENSE - MEDICARE	A	-44,509	ADMINISTRATIVE & GENERAL	4.00	25.08
25.09	BAD DEBT EXPENSE - OTHER	A	-164	ADMINISTRATIVE & GENERAL	4.00	25.09
25.10	OTHER MEDICAL SERVICES EXPENSE	A	-25,170	SKILLED NURSING FACILITY	30.00	25.10
25.11	MAINTENANCE FEE INCOME	B	-1,900	CAP REL COSTS - BLDGS & FIXTURES	1.00	25.11
25.12	OTHER REVENUE	B	-6,523	ADMINISTRATIVE & GENERAL	4.00	25.12
25.13	OTHER INCOME	B	-6,015	ADMINISTRATIVE & GENERAL	4.00	25.13
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-861,173			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. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet A-8-1  
Parts I-III  
Date/Time Prepared:  
5/15/2024 12:23 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	MANAGEMENT FEES	2.00
3.00		9.00	NURSING ADMINISTRATION	PHARMACY CONSULTANT	3.00
4.00		10.00	CENTRAL SERVICES & SUPPLY	WOUND CARE EXPENSE	4.00
5.00		11.00	PHARMACY	DRUGS-NON-PRESCRIPTION, NON-LEGEND	5.00
6.00		11.00	PHARMACY	PHARMACY SUPPLIES	6.00
7.00		42.00	INTRAVENOUS THERAPY	IV EXPENSE	7.00
8.00		49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND	8.00
9.00		49.00	DRUGS CHARGED TO PATIENTS	DRUGS OTH	9.00
9.01		49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND	9.01
9.02		0.00		DRUGS MAN	9.02
9.03		0.00		DRUGS-PRESCRIPTION, MEDICARE A	9.03
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		3,750,123	3,812,672	-62,549	1.00
2.00		616,208	891,941	-275,733	2.00
3.00		27,146	29,507	-2,361	3.00
4.00		74,726	74,726	0	4.00
5.00		13,609	14,792	-1,183	5.00
6.00		512	557	-45	6.00
7.00		377,845	410,701	-32,856	7.00
8.00		23,667	25,725	-2,058	8.00
9.00		267,541	290,805	-23,264	9.00
9.01		366,108	397,943	-31,835	9.01
9.02		0	0	0	9.02
9.03		0	0	0	9.03
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	5,517,485	5,949,369	-431,884	10.00

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

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet A-8-1  
Parts I-II  
Date/Time Prepared:  
5/15/2024 12:23 pm

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

## PART I. 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	CARE ONE	100.00	1.00
2.00	A	CARE ONE	100.00	2.00
3.00	A	CARE ONE	100.00	3.00
4.00	A	CARE ONE	100.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) 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	493 BLACK OAK RIDGE ROAD	100.00	REALTY	1.00
2.00	HEALTHBRIDGE MANAGEMENT	100.00	HOME OFFICE	2.00
3.00	PARTNERS PHARMACY	64.87	PHARMACY	3.00
4.00	TOTAL CARE LLC	100.00	WOUND CARE	4.00
5.00		0.00		5.00
6.00		0.00		6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) 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. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part I  
Date/Time Prepared:  
5/15/2024 12:23 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	3.00	3A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	4,073,917	4,073,917			1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	47,965		47,965		2.00
3.00	00300	EMPLOYEE BENEFITS	910,986	0	910,986		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	1,892,625	107,585	1,267	2,078,409	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	547,296	132,121	1,556	686,366	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	67,517	0	3,157	70,674	6.00
7.00	00700	HOUSEKEEPING	390,089	39,694	467	473,017	7.00
8.00	00800	DIETARY	805,615	90,083	1,061	958,811	8.00
9.00	00900	NURSING ADMINISTRATION	540,615	16,987	200	621,324	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	224,301	66,061	778	294,877	10.00
11.00	01100	PHARMACY	14,121	3,832	45	17,998	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	47,533	3,089	36	56,487	12.00
13.00	01300	SOCIAL SERVICE	154,199	28,083	331	201,523	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	ACTIVITIES	213,352	0	0	238,203	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	3,103,249	2,236,055	26,326	5,763,761	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	179,618	1,211,685	14,266	1,405,569	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	64,728	0	0	64,728	40.00
41.00	04100	LABORATORY	102,476	0	0	102,476	41.00
42.00	04200	INTRAVENOUS THERAPY	377,845	0	0	377,845	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	954,961	88,253	1,039	1,159,045	44.00
45.00	04500	OCCUPATIONAL THERAPY	632,271	36,548	430	746,788	45.00
46.00	04600	SPEECH PATHOLOGY	109,057	5,262	62	127,755	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,897	0	0	14,897	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	657,316	0	0	657,316	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	20,923	0	0	20,923	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	64,737	0	0	64,737	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)	16,212,209	4,065,338	47,864	16,203,529	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	11,658	0	0	11,658	90.00
91.00	09100	BARBER AND BEAUTY SHOP	9,184	8,579	101	17,864	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	16,233,051	4,073,917	47,965	16,233,051	100.00

## COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part I  
Date/Time Prepared:  
5/15/2024 12:23 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	2,078,409				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	100,783	787,149			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	10,377	0	81,051		6.00
7.00	00700	HOUSEKEEPING	69,456	8,149	0	550,622	7.00
8.00	00800	DIETARY	140,788	18,494	0	13,072	1,131,165
9.00	00900	NURSING ADMINISTRATION	91,233	3,487	0	2,465	0
10.00	01000	CENTRAL SERVICES & SUPPLY	43,299	13,562	0	9,586	0
11.00	01100	PHARMACY	2,643	787	0	556	0
12.00	01200	MEDICAL RECORDS & LIBRARY	8,294	634	0	448	0
13.00	01300	SOCIAL SERVICE	29,591	5,765	0	4,075	0
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0
15.00	01500	ACTIVITIES	34,977	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	846,326	459,055	72,883	324,474	1,017,176
31.00	03100	NURSING FACILITY	0	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	206,388	248,754	8,168	175,828	113,989
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	9,504	0	0	0	0
41.00	04100	LABORATORY	15,047	0	0	0	0
42.00	04200	INTRAVENOUS THERAPY	55,481	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00	04400	PHYSICAL THERAPY	170,190	18,118	0	12,806	0
45.00	04500	OCCUPATIONAL THERAPY	109,655	7,503	0	5,303	0
46.00	04600	SPEECH PATHOLOGY	18,759	1,080	0	764	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,187	0	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	96,518	0	0	0	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	3,072	0	0	0	0
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0
52.02	05202	MEDICAL SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	0
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00	06200	FQHC	0	0	0	0	0
63.00	06300	DIALYSIS	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00	07100	AMBULANCE	9,506	0	0	0	0
73.00	07300	CMHC	0	0	0	0	0
74.00	07400	OTHER REIMBURSEMENT	0	0	0	0	0
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
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	2,074,074	785,388	81,051	549,377	1,131,165
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1,712	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	2,623	1,761	0	1,245	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0
98.00		Cross Foot Adjustments	0	0	0	0	0
99.00		Negative Cost Centers	0	0	0	0	0
100.00		TOTAL	2,078,409	787,149	81,051	550,622	1,131,165

## COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part I  
Date/Time Prepared:  
5/15/2024 12:23 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	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	718,509				9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	361,324			10.00
11.00	01100	PHARMACY	0	0	21,984		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	65,863	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	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	646,104	324,913	19,769	59,226	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	72,405	36,411	2,215	6,637	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	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	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)	718,509	361,324	21,984	65,863	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	0	0	0	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	718,509	361,324	21,984	65,863	100.00



## COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part I  
Date/Time Prepared:  
5/15/2024 12:23 pm

Cost Center Description			NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total	
			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	273,180				15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	0	245,651	9,996,011	0	9,996,011	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	27,529	2,328,174	0	2,328,174	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	74,232	0	74,232	40.00
41.00	04100	LABORATORY	0	0	117,523	0	117,523	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	433,326	0	433,326	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	1,360,159	0	1,360,159	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	869,249	0	869,249	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	148,358	0	148,358	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	17,084	0	17,084	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	753,834	0	753,834	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	23,995	0	23,995	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						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	74,243	0	74,243	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)	0	273,180	16,196,188	0	16,196,188	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	13,370	0	13,370	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	23,493	0	23,493	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	0	273,180	16,233,051	0	16,233,051	100.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part II  
Date/Time Prepared:  
5/15/2024 12:23 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
			Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	MOVABLE EQUIPMENT		
			0	1.00	2.00	2A	3.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	107,585	1,267	108,852	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	132,121	1,556	133,677	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	00700	HOUSEKEEPING	0	39,694	467	40,161	7.00
8.00	00800	DIETARY	0	90,083	1,061	91,144	8.00
9.00	00900	NURSING ADMINISTRATION	0	16,987	200	17,187	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	66,061	778	66,839	10.00
11.00	01100	PHARMACY	0	3,832	45	3,877	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	3,089	36	3,125	12.00
13.00	01300	SOCIAL SERVICE	0	28,083	331	28,414	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	2,236,055	26,326	2,262,381	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	1,211,685	14,266	1,225,951	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	88,253	1,039	89,292	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	36,548	430	36,978	45.00
46.00	04600	SPEECH PATHOLOGY	0	5,262	62	5,324	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					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	4,065,338	47,864	4,113,202	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	8,579	101	8,680	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	4,073,917	47,965	4,121,882	100.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part II  
Date/Time Prepared:  
5/15/2024 12:23 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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	108,852				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5,278	138,955			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	543	0	543		6.00
7.00	00700	HOUSEKEEPING	3,638	1,439	0	45,238	7.00
8.00	00800	DIETARY	7,373	3,265	0	1,074	8.00
9.00	00900	NURSING ADMINISTRATION	4,778	616	0	203	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	2,268	2,394	0	788	10.00
11.00	01100	PHARMACY	138	139	0	46	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	434	112	0	37	12.00
13.00	01300	SOCIAL SERVICE	1,550	1,018	0	335	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	ACTIVITIES	1,832	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	44,325	81,034	488	26,656	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	10,809	43,913	55	14,446	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	RADIOLOGY	498	0	0	0	40.00
41.00	04100	LABORATORY	788	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	2,906	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	8,913	3,198	0	1,052	44.00
45.00	04500	OCCUPATIONAL THERAPY	5,743	1,325	0	436	45.00
46.00	04600	SPEECH PATHOLOGY	982	191	0	63	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	115	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	5,055	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	161	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	07100	AMBULANCE	498	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
<b>SPECIAL PURPOSE COST CENTERS</b>							
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)	108,625	138,644	543	45,136	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	90	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	137	311	0	102	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	98.00
99.00		Negative Cost Centers	0	0	0	0	99.00
100.00		TOTAL	108,852	138,955	543	45,238	100.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part II  
Date/Time Prepared:  
5/15/2024 12:23 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	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	22,784				9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	72,289			10.00
11.00	01100	PHARMACY	0	0	4,200		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	3,708	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	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	20,488	65,004	3,777	3,334	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	2,296	7,285	423	374	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	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	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)	22,784	72,289	4,200	3,708	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	0	0	0	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	22,784	72,289	4,200	3,708	100.00

## ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet B  
Part II  
Date/Time Prepared:  
5/15/2024 12:23 pm

Cost Center Description			NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
				ACTI V I T E S				
				14. 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	1, 832				15. 00
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00	03000	SKILLED NURSING FACILITY	0	1, 647	2, 629, 786	0	2, 629, 786	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	185	1, 319, 258	0	1, 319, 258	33. 00
ANCILLARY SERVICE COST CENTERS								
40. 00	04000	RADIOLOGY	0	0	498	0	498	40. 00
41. 00	04100	LABORATORY	0	0	788	0	788	41. 00
42. 00	04200	INTRAVENOUS THERAPY	0	0	2, 906	0	2, 906	42. 00
43. 00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400	PHYSICAL THERAPY	0	0	102, 455	0	102, 455	44. 00
45. 00	04500	OCCUPATIONAL THERAPY	0	0	44, 482	0	44, 482	45. 00
46. 00	04600	SPEECH PATHOLOGY	0	0	6, 560	0	6, 560	46. 00
47. 00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47. 00
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	115	0	115	48. 00
49. 00	04900	DRUGS CHARGED TO PATIENTS	0	0	5, 055	0	5, 055	49. 00
50. 00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00	05100	SUPPORT SURFACES	0	0	161	0	161	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						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	498	0	498	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)	0	1, 832	4, 112, 562	0	4, 112, 562	89. 00
NONREIMBURSABLE COST CENTERS								
90. 00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90	0	90	90. 00
91. 00	09100	BARBER AND BEAUTY SHOP	0	0	9, 230	0	9, 230	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	0	1, 832	4, 121, 882	0	4, 121, 882	100. 00

## COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315477

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

Worksheet B-1

Date/Time Prepared:  
5/15/2024 12:23 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				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	71,228					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		71,228				2.00
3.00	00300	EMPLOYEE BENEFITS	0	0	7,428,376			3.00
4.00	00400	ADMINISTRATIVE & GENERAL	1,881	1,881	627,318	-2,078,409	14,154,642	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	2,310	2,310	43,975	0	686,366	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	25,739	0	70,674	6.00
7.00	00700	HOUSEKEEPING	694	694	348,735	0	473,017	7.00
8.00	00800	DIETARY	1,575	1,575	505,987	0	958,811	8.00
9.00	00900	NURSING ADMINISTRATION	297	297	517,969	0	621,324	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	1,155	1,155	30,472	0	294,877	10.00
11.00	01100	PHARMACY	67	67	0	0	17,998	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	54	54	47,533	0	56,487	12.00
13.00	01300	SOCIAL SERVICE	491	491	154,199	0	201,523	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	0	0	202,643	0	238,203	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	39,095	39,095	3,246,441	0	5,763,761	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	21,185	21,185	0	0	1,405,569	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	64,728	40.00
41.00	04100	LABORATORY	0	0	0	0	102,476	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	377,845	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1,543	1,543	936,037	0	1,159,045	44.00
45.00	04500	OCCUPATIONAL THERAPY	639	639	632,271	0	746,788	45.00
46.00	04600	SPEECH PATHOLOGY	92	92	109,057	0	127,755	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	14,897	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	657,316	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	20,923	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	64,737	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)	71,078	71,078	7,428,376	-2,078,409	14,125,120	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	11,658	90.00
91.00	09100	BARBER AND BEAUTY SHOP	150	150	0	0	17,864	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)	4,073,917	47,965	910,986		2,078,409	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	57.195443	0.673401	0.122636		0.146836	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)			0		108,852	104.00

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 II)			0.000000	4A	0.007690	105.00

## COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315477

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

Worksheet B-1

Date/Time Prepared:  
5/15/2024 12:23 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	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	67,037					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	26,972				6.00
7.00	00700	HOUSEKEEPING	694	0	66,343			7.00
8.00	00800	DIETARY	1,575	0	1,575	80,916		8.00
9.00	00900	NURSING ADMINISTRATION	297	0	297	0	26,972	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	1,155	0	1,155	0	0	10.00
11.00	01100	PHARMACY	67	0	67	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	54	0	54	0	0	12.00
13.00	01300	SOCIAL SERVICE	491	0	491	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	39,095	24,254	39,095	72,762	24,254	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	21,185	2,718	21,185	8,154	2,718	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1,543	0	1,543	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	639	0	639	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	92	0	92	0	0	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	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	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	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)	66,887	26,972	66,193	80,916	26,972	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	150	0	150	0	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						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	787,149	81,051	550,622	1,131,165	718,509	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	11.742008	3.005005	8.299625	13.979497	26.639070	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	138,955	543	45,238	102,856	22,784	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	2.072811	0.020132	0.681881	1.271145	0.844728	105.00



## COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315477

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

Worksheet B-1

Date/Time Prepared:  
5/15/2024 12:23 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	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	26,972					10.00
11.00	01100	PHARMACY	0	26,972				11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	26,972			12.00
13.00	01300	SOCIAL SERVICE	0	0	0	26,972		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	24,254	24,254	24,254	24,254	0	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	2,718	2,718	2,718	2,718	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	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	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	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	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)	26,972	26,972	26,972	26,972	0	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	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)	361,324	21,984	65,863	240,954	0	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	13.396263	0.815067	2.441903	8.933487	0.000000	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	72,289	4,200	3,708	31,317	0	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	2.680150	0.155717	0.137476	1.161093	0.000000	105.00

## COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315477

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

Worksheet B-1

Date/Time Prepared:  
5/15/2024 12:23 pm

Cost Center Description		OTHER GENERAL		
		SERVICE		
		ACTI VI TES (PATI ENT 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	26,972	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	24,254	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	2,718	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		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)	26,972	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)	273,180	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	10.128281	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	1,832	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.067922	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315477

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

Worksheet C

Date/Time Prepared:  
5/15/2024 12:23 pm

Cost Center Description			Total (from Wkst. B, Pt I, 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	74,232	161,820	0.458732	40.00
41.00	04100	LABORATORY	117,523	256,190	0.458734	41.00
42.00	04200	INTRAVENOUS THERAPY	433,326	1,026,753	0.422035	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	1,360,159	3,698,189	0.367791	44.00
45.00	04500	OCCUPATIONAL THERAPY	869,249	3,068,348	0.283295	45.00
46.00	04600	SPEECH PATHOLOGY	148,358	440,325	0.336928	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,084	37,242	0.458729	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	753,834	1,786,182	0.422037	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	23,995	52,307	0.458734	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	74,243	161,842	0.458738	71.00
100.00		Total	3,872,003	10,689,198		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Provider No. : 315477		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/15/2024 12: 23 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	0.458732	34,559	0	15,853	0	40.00	
41.00	04100	LABORATORY	0.458734	72,171	0	33,107	0	41.00	
42.00	04200	INTRAVENOUS THERAPY	0.422035	74,732	0	31,540	0	42.00	
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00	
44.00	04400	PHYSICAL THERAPY	0.367791	1,833,067	0	674,186	0	44.00	
45.00	04500	OCCUPATIONAL THERAPY	0.283295	1,539,633	0	436,170	0	45.00	
46.00	04600	SPEECH PATHOLOGY	0.336928	216,108	0	72,813	0	46.00	
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00	
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.458729	37,242	0	17,084	0	48.00	
49.00	04900	DRUGS CHARGED TO PATIENTS	0.422037	230,194	0	97,150	0	49.00	
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0.000000	0		0		50.00	
51.00	05100	SUPPORT SURFACES	0.458734	52,307	0	23,995	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)	0.458738		0		0	71.00	
100.00		Total (Sum of lines 40 - 71)		4,090,013	0	1,401,898	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. : 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/15/2024 12:23 pm
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description						1.00
PART II - APPORTIONMENT OF VACCINE COST						
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)				0.422037
2.00		Program vaccine charges (From your records, or the PS&R)				0
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)				0
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	74,232	0	0.000000	15,853
41.00	04100	LABORATORY	117,523	0	0.000000	33,107
42.00	04200	INTRAVENOUS THERAPY	433,326	0	0.000000	31,540
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0
44.00	04400	PHYSICAL THERAPY	1,360,159	0	0.000000	674,186
45.00	04500	OCCUPATIONAL THERAPY	869,249	0	0.000000	436,170
46.00	04600	SPEECH PATHOLOGY	148,358	0	0.000000	72,813
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,084	0	0.000000	17,084
49.00	04900	DRUGS CHARGED TO PATIENTS	753,834	0	0.000000	97,150
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0
51.00	05100	SUPPORT SURFACES	23,995	0	0.000000	23,995
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	0
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0.000000	0
52.02	05202	MEDICAL SERVICES	0	0	0.000000	0
100.00		Total (Sum of lines 40 - 52)	3,797,760	0		1,401,898

COMPUTATION OF INPATIENT ROUTINE COSTS		Provider No. : 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/15/2024 12:23 pm
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
<b>PART I CALCULATION OF INPATIENT ROUTINE COSTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days including private room days		24,254	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		12,544	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		9,996,011	5.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
6.00	General inpatient routine service charges		16,382,393	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.610168	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)		9,996,011	15.00
<b>PROGRAM INPATIENT ROUTINE SERVICE COSTS</b>				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		412.14	16.00
17.00	Program routine service cost (Line 3 times line 16)		5,169,884	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)		5,169,884	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)		2,629,786	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		108.43	21.00
22.00	Program capital related cost (Line 3 times line 21)		1,360,146	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		3,809,738	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)		3,809,738	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	
<b>PART II CALCULATION OF INPATIENT NURSING &amp; ALLIED HEALTH COSTS FOR PPS PASS-THROUGH</b>				
1.00	Total SNF inpatient days		24,254	1.00
2.00	Program inpatient days (see instructions)		12,544	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)		0.517193	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. : 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/15/2024 12:23 pm
		Title XIX	Skilled Nursing Facility	
				1.00
<b>PART I CALCULATION OF INPATIENT ROUTINE COSTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days including private room days		24,254	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		0	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		9,996,011	5.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
6.00	General inpatient routine service charges		16,382,393	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.610168	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)		9,996,011	15.00
<b>PROGRAM INPATIENT ROUTINE SERVICE COSTS</b>				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		412.14	16.00
17.00	Program routine service cost (Line 3 times line 16)		0	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)		0	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)		2,629,786	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		108.43	21.00
22.00	Program capital related cost (Line 3 times line 21)		0	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		0	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)		0	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)		0	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
<b>PART II CALCULATION OF INPATIENT NURSING &amp; ALLIED HEALTH COSTS FOR PPS PASS-THROUGH</b>				
1.00	Total SNF inpatient days		24,254	1.00
2.00	Program inpatient days (see instructions)		0	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)		0.000000	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. : 315477	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/15/2024 12:23 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
<b>PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT</b>				
1.00	Inpatient PPS amount (See Instructions)		11,264,916	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)		11,264,916	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinurance		1,068,400	5.00
6.00	Allowable bad debts (From your records)		120,804	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		78,523	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)		10,275,039	11.00
12.00	Interim payments (See instructions)		10,163,953	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		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		1,570	14.75
14.99	Sequestration amount (see instructions)		203,931	14.99
15.00	Balance due provider/program (see Instructions)		-94,415	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
<b>PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY</b>				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinurance 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)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	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. : 315477

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

Worksheet E-1

Date/Time Prepared:  
5/15/2024 12:23 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				0	1.00
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		9,992,585 147,868		0	2.00
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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/06/2023	23,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		23,500		0	3.99
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)		10,163,953		0	4.00
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)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		0		0	6.01
6.02	PROVIDER TO PROGRAM		94,415		0	6.02
7.00	Total Medicare program liability (see instructions)		10,069,538		0	7.00
			Contractor Name		Contractor Number	
			1.00		2.00	
8.00	Name of Contractor					8.00

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

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

Provider No. : 315477

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

Worksheet G

Date/Time Prepared:  
5/15/2024 12:23 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
<b>Assets</b>					
<b>CURRENT ASSETS</b>					
1.00 Cash on hand and in banks	662,595	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	2,644,376	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	-305,936	0	0	0	6.00
7.00 Inventory	0	0	0	0	7.00
8.00 Prepaid expenses	18,348	0	0	0	8.00
9.00 Other current assets	147,066	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)	3,166,449	0	0	0	11.00
<b>FIXED ASSETS</b>					
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	5,491	0	0	0	27.00
28.00 TOTAL FIXED ASSETS (Sum of lines 12 - 27)	5,491	0	0	0	28.00
<b>OTHER ASSETS</b>					
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	588,550	0	0	0	32.00
33.00 TOTAL OTHER ASSETS (Sum of lines 29 - 32)	588,550	0	0	0	33.00
34.00 TOTAL ASSETS (Sum of lines 11, 28, and 33)	3,760,490	0	0	0	34.00
<b>Liabilities and Fund Balances</b>					
<b>CURRENT LIABILITIES</b>					
35.00 Accounts payable	1,774,574	0	0	0	35.00
36.00 Salaries, wages, and fees payable	-222,418	0	0	0	36.00
37.00 Payroll taxes payable	-121,418	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	134,181	0	0	0	41.00
42.00 Other current liabilities	1,912,879	0	0	0	42.00
43.00 TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3,477,798	0	0	0	43.00
<b>LONG TERM LIABILITIES</b>					
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	-43,968,106	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)	-43,968,106	0	0	0	50.00
51.00 TOTAL LIABILITIES (Sum of lines 43 and 50)	-40,490,308	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>					
52.00 General fund balance	44,250,798	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)	44,250,798	0	0	0	59.00
60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	3,760,490	0	0	0	60.00

## STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315477

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

Worksheet G-1

Date/Time Prepared:  
5/15/2024 12:23 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		43,335,172		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		915,633				2.00
3.00	Total (sum of line 1 and line 2)		44,250,805		0		3.00
4.00	Additions (credit adjustments)						4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		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)		44,250,805		0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDING	7		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		7		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		44,250,798		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. : 315477

Period:  
From 01/01/2023  
To 12/31/2023Worksheet G-2  
Parts I-II  
Date/Time Prepared:  
5/15/2024 12:23 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	16,382,393		16,382,393	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)	16,382,393		16,382,393	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	10,689,198	0	10,689,198	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)	27,071,591	0	27,071,591	14.00
Cost Center Description					
			1.00	2.00	
<b>PART II - OPERATING EXPENSES</b>					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			17,094,224	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)			17,094,224	15.00

## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315477

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

Worksheet G-3

Date/Time Prepared:  
5/15/2024 12:23 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	27,071,591	1.00
2.00	Less: contractual allowances and discounts on patients accounts	9,083,817	2.00
3.00	Net patient revenues (Line 1 minus line 2)	17,987,774	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	17,094,224	4.00
5.00	Net income from service to patients (Line 3 minus 4)	893,550	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,095	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	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	BARBER AND BEAUTY	5,550	24.00
24.01	MAINT FEE INCOME	1,900	24.01
24.02	OTHER REV	6,523	24.02
24.03	OTHER INCOME	6,015	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	22,083	25.00
26.00	Total (Line 5 plus line 25)	915,633	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)	915,633	31.00