

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: 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/2/2024 10:05 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROOSEVELT CARE CENTER (315039) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1	1 Mark Sorrento	2 Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Mark Sorrento		2
3	Signatory Title	ADMINISTRATOR		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-31,239	953	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	-31,239	953	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. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/2/2024 10:05 am			
1.00		2.00		3.00			
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:							
1.00	Street: 118 PARSONAGE RD	PO Box:				1.00	
2.00	City: EDISON	State: NJ	Zip Code: 08837			2.00	
3.00	County: MIDDLESEX	CBSA Code: 35154	Urban/Rural: U			3.00	
3.01		CBSA Code:				3.01	
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)		
		1.00	2.00	3.00	V	XVIII	XIX
SNF and SNF-Based Component Identification:							
4.00	SNF	ROOSEVELT CARE CENTER	315039	01/01/1967	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 FOHC						
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)				9		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?					N	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	
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	
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	
19.01	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	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.							
20.00	Straight Line					851,085	
21.00	Declining Balance					0	
22.00	Sum of the Year's Digits					0	
23.00	Sum of line 20 through 22					851,085	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	
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	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	
				Part A	Part B	Other	
				1.00	2.00	3.00	
29.00	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.						
29.00	Skilled Nursing Facility					N	
30.00	Nursing Facility					N	
31.00	ICF/IID					N	
32.00	SNF-Based HHA					N	
33.00	SNF-Based RHC					N	
34.00	SNF-Based FOHC					N	
35.00	SNF-Based CMHC					N	
36.00	SNF-Based OLTC					N	
				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)					Y	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N	
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.						
			Premiums	Paid Losses	Self Insurance		
			1.00	2.00	3.00		
41.00	List malpractice premiums and paid losses:		0	0	0		41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/2/2024 10:05 am
				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?			N 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.			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:	Contractor's Name:	Contractor's Number:	45.00
46.00	Street:	PO Box:		46.00
47.00	City:	State:	Zip Code:	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/2/2024 10:05 am	
		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	03/15/2024	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. : 315039

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/2/2024 10:05 am

		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.	SLAVKA	PARTI LOVA	19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	SLAVKA.PARTILOVA@HCRNJ.NET	21.00

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

Provider No. : 315039

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/2/2024 10:05 am

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/15/2024	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PREPARER	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. : 315039

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/2/2024 10:05 am

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	356	129,940	0	9,738	41,773	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	356	129,940	0	9,738	41,773	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	8,148	59,659	0	183	25	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	8,148	59,659	0	183	25	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	231	439	0.00	53.21	1,670.92	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	231	439	0.00	53.21	1,670.92	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	135.90	0	246	16	161	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	135.90	0	246	16	161	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	423	153.70	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	423	153.70	0.00	8.00		

Provider No. : 315039

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

Worksheet S-3
Part II
Date/Time Prepared:
5/2/2024 10:05 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	8,773,945	0	8,773,945	319,726.00	27.44 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	8,773,945	0	8,773,945	319,726.00	27.44 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	8,773,945	0	8,773,945	319,726.00	27.44 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	5,908,410	0	5,908,410	130,011.00	45.45 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	4,909,967	0	4,909,967		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	4,909,967	0	4,909,967		

Provider No. : 315039

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

Worksheet S-3
Part III
Date/Time Prepared:
5/2/2024 10:05 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	755,644	0	755,644	32,009.00	2.00
3.00	Plant Operation, Maintenance & Repairs	130,008	0	130,008	6,791.00	3.00
4.00	Laundry & Linen Service	0	0	0	0.00	4.00
5.00	Housekeeping	298,545	0	298,545	14,775.00	5.00
6.00	Dietary	1,096,624	0	1,096,624	54,140.00	6.00
7.00	Nursing Administration	1,280,067	0	1,280,067	30,412.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	159,444	0	159,444	3,960.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	389,635	0	389,635	14,475.00	13.00
14.00	Total (sum lines 1 thru 13)	4,109,967	0	4,109,967	156,562.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/2/2024 10:05 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	1,074,690	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)	2,039,008	8.00
9.00	Prescription Drug Plan	764,064	9.00
10.00	Dental, Hearing and Vision Plan	73,055	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	247,654	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	707,746	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	0	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	3,750	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	4,909,967	24.00
		Amount Reported	
		1.00	
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315039

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

Worksheet S-3
Part V
Date/Time Prepared:
5/2/2024 10:05 am

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	775,604	820,899	1,596,503	18,163.00	87.90	1.00
2.00	Licensed Practical Nurses (LPNs)	1,044,287	1,105,273	2,149,560	30,405.00	70.70	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,577,998	2,728,553	5,306,551	114,599.00	46.31	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4,397,889	4,654,725	9,052,614	163,167.00	55.48	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	856,224		856,224	9,931.00	86.22	14.00
15.00	Licensed Practical Nurses (LPNs)	2,147,004		2,147,004	54,122.00	39.67	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,460,456		1,460,456	47,704.00	30.61	16.00
17.00	Total Nursing (sum of lines 14 through 16)	4,463,684		4,463,684	111,757.00	39.94	17.00
18.00	Physical Therapists	338,817		338,817	4,905.00	69.08	18.00
19.00	Physical Therapy Assistants	235,273		235,273	3,406.00	69.08	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	320,063		320,063	3,644.00	87.83	21.00
22.00	Occupational Therapy Assistants	384,789		384,789	4,381.00	87.83	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	165,784		165,784	1,918.00	86.44	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315039

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

Worksheet S-7
Date/Time Prepared:
5/2/2024 10:05 am

		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. : 315039

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

Worksheet S-7

Date/Time Prepared:
5/2/2024 10:05 am

		Group	Days	
76.00		1.00	2.00	
99.00		PA1		76.00
100.00	TOTAL	AAA		99.00
				100.00
		Expenses	Percentage	Y/N
		1.00	2.00	3.00
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)				
101.00	Staffing			101.00
102.00	Recruitment			102.00
103.00	Retention of employees			103.00
104.00	Training			104.00
105.00	OTHER (SPECIFY)			105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)			106.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315039

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

Worksheet A
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1,369,152	1,369,152	0	1,369,152	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		0	0	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	9,286,043	9,286,043	0	9,286,043	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	755,644	2,789,846	3,545,490	0	3,545,490	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	130,008	1,001,872	1,131,880	0	1,131,880	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	328,188	328,188	0	328,188	6.00
7.00	00700	HOUSEKEEPING	298,545	657,473	956,018	0	956,018	7.00
8.00	00800	DIETARY	1,096,624	853,730	1,950,354	0	1,950,354	8.00
9.00	00900	NURSING ADMINISTRATION	1,280,067	129,701	1,409,768	0	1,409,768	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	487,128	487,128	0	487,128	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	159,444	0	159,444	0	159,444	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	389,635	15,868	405,503	0	405,503	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	4,663,978	4,545,813	9,209,791	0	9,209,791	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	32,203	32,203	0	32,203	40.00
41.00	04100	LABORATORY	0	18,799	18,799	0	18,799	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	82,698	82,698	0	82,698	43.00
44.00	04400	PHYSICAL THERAPY	0	404,649	404,649	0	404,649	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	841,805	841,805	0	841,805	45.00
46.00	04600	SPEECH PATHOLOGY	0	197,996	197,996	0	197,996	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	427,136	427,136	0	427,136	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
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
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
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
89.00		SUBTOTALS (sum of lines 1-84)	8,773,945	23,470,100	32,244,045	0	32,244,045	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	136	136	0	136	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	IDLE SPACE	0	0	0	0	0	95.00
100.00		TOTAL	8,773,945	23,470,236	32,244,181	0	32,244,181	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/2/2024 10:05 am
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Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-259,758	1,109,394	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	-4,200,228	5,085,815	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-325,473	3,220,017	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	1,131,880	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	328,188	6.00
7.00	00700	HOUSEKEEPING	0	956,018	7.00
8.00	00800	DIETARY	0	1,950,354	8.00
9.00	00900	NURSING ADMINISTRATION	0	1,409,768	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	487,128	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	159,444	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	405,503	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	9,209,791	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	32,203	40.00
41.00	04100	LABORATORY	0	18,799	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	82,698	43.00
44.00	04400	PHYSICAL THERAPY	0	404,649	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	841,805	45.00
46.00	04600	SPEECH PATHOLOGY	0	197,996	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	427,136	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
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	FOHC	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
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
89.00		SUBTOTALS (sum of lines 1-84)	-4,785,459	27,458,586	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	136	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	IDLE SPACE	0	0	95.00
100.00		TOTAL	-4,785,459	27,458,722	100.00

Provider No. : 315039

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

Worksheet A-6
Date/Time Prepared:
5/2/2024 10:05 am

		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Recl assi fi cations (Sum of col umns 4 and 5 must equal sum of col umns 8 and 9)				0	0 100.00

(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. : 315039

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

Worksheet A-6

Date/Time Prepared:
5/2/2024 10:05 am

		Decreases			
		Cost Center	Line #	Salary	Non Salary
		6.00	7.00	8.00	9.00
100.00	TOTALS			0	0
					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. : 315039

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

Worksheet A-7

Date/Time Prepared:
5/2/2024 10:05 am

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
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	21,972,610	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	6,142,756	0	0	0	0	6.00
7.00 Subtotal (sum of lines 1-6)	28,115,366	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)	28,115,366	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				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	21,972,610	0				
4.00 Building Improvements	0	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	6,142,756	0				
7.00 Subtotal (sum of lines 1-6)	28,115,366	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	28,115,366	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315039

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

Worksheet A-8
Date/Time Prepared:
5/2/2024 10:05 am

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	-259,758	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	114,421				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals		0			0.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Vending machines		0			0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00	22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT		2.00	24.00
25.00 Other adjustment (specify)		0			0.00	25.00
25.02 MISC / REFUNDS	B	-1	ADMINISTRATIVE & GENERAL		4.00	25.02
25.03 MISSING ITEM	A	-796	ADMINISTRATIVE & GENERAL		4.00	25.03
25.04 PROFESSIONAL SERVICES / LEGAL	A	-97,412	ADMINISTRATIVE & GENERAL		4.00	25.04
25.05 MARKETING	A	-6,286	ADMINISTRATIVE & GENERAL		4.00	25.05
25.06 BAD DEBTS	A	-335,399	ADMINISTRATIVE & GENERAL		4.00	25.06
25.07 FRINGE BENEFITS	A	-4,200,228	EMPLOYEE BENEFITS		3.00	25.07
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-4,785,459				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. : 315039

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/2/2024 10:05 am

		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		4.00	ADMINISTRATIVE & GENERAL	COUNTY ADMINISTRATIVE COSTS	1.00
2.00		4.00	ADMINISTRATIVE & GENERAL	TECHNICAL SUPPORT	2.00
3.00		0.00			3.00
4.00		0.00			4.00
5.00		0.00			5.00
6.00		0.00			6.00
7.00		0.00			7.00
8.00		0.00			8.00
9.00		0.00			9.00
10.00	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		249,959	249,959	0	1.00
2.00		114,421	0	114,421	2.00
3.00		0	0	0	3.00
4.00		0	0	0	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	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	364,380	249,959	114,421	10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/2/2024 10:05 am
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Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00		G	MCIA	0.00	1.00
2.00		G	MIDDLESEX COUNTY	0.00	2.00
3.00				0.00	3.00
4.00				0.00	4.00
5.00				0.00	5.00
6.00				0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) 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		MCIA	0.00	COUNTY IMPROVEMENT AUTHORITY	1.00
2.00		MIDDLESEX COUNTY	0.00	COUNTY GOVERNMENT	2.00
3.00			0.00		3.00
4.00			0.00		4.00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) 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. : 315039

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

Worksheet B
Part I
Date/Time Prepared:
5/2/2024 10:05 am

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	1,109,394	1,109,394			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	5,085,815	0	0	5,085,815	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,220,017	174,720	0	438,009	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,131,880	31,986	0	75,359	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	328,188	33,382	0	0	6.00
7.00 00700	HOUSEKEEPING	956,018	10,945	0	173,052	7.00
8.00 00800	DIETARY	1,950,354	39,853	0	635,658	8.00
9.00 00900	NURSING ADMINISTRATION	1,409,768	3,420	0	741,991	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	487,128	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	5,322	0	0	12.00
13.00 01300	SOCIAL SERVICE	159,444	7,388	0	92,422	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	405,503	54,834	0	225,852	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	9,209,791	717,693	0	2,703,472	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	32,203	0	0	0	40.00
41.00 04100	LABORATORY	18,799	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	82,698	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	404,649	10,753	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	841,805	10,753	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	197,996	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	427,136	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
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	62.00
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
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
89.00	SUBTOTALS (sum of lines 1-84)	27,458,586	1,101,049	0	5,085,815	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	136	8,345	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	IDLE SPACE	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	27,458,722	1,109,394	0	5,085,815	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315039

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

Worksheet B
Part I
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	3,832,746				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	201,035	1,440,260			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	58,656	53,261	473,487		6.00	
7.00	00700	HOUSEKEEPING	184,940	17,463	0	1,342,418	7.00	
8.00	00800	DIETARY	425,984	63,586	0	62,327	3,177,762	8.00
9.00	00900	NURSING ADMINISTRATION	349,626	5,457	0	5,349	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	79,025	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	863	8,491	0	8,323	0	12.00
13.00	01300	SOCIAL SERVICE	42,058	11,787	0	11,554	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	111,318	87,488	0	85,756	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	2,049,066	1,145,098	473,487	1,122,423	3,177,762	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	5,224	0	0	0	0	40.00
41.00	04100	LABORATORY	3,050	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	13,416	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	67,389	17,157	0	16,817	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	138,307	17,157	0	16,817	0	45.00
46.00	04600	SPEECH PATHOLOGY	32,120	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	69,293	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
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
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
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
89.00		SUBTOTALS (sum of lines 1-84)	3,831,370	1,426,945	473,487	1,329,366	3,177,762	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	1,376	13,315	0	13,052	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	IDLE SPACE	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	3,832,746	1,440,260	473,487	1,342,418	3,177,762	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315039

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

Worksheet B
Part I
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	2,515,611					9.00
10.00	01000		566,153				10.00
11.00	01100						11.00
12.00	01200				22,999		12.00
13.00	01300					324,653	13.00
14.00	01400						14.00
15.00	01500						15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,515,611	301,651		22,999	324,653	30.00
31.00	03100						31.00
32.00	03200						32.00
33.00	03300						33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000						40.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
44.00	04400						44.00
45.00	04500						45.00
46.00	04600						46.00
47.00	04700						47.00
48.00	04800						48.00
49.00	04900		264,502				49.00
50.00	05000						50.00
51.00	05100						51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000						60.00
61.00	06100						61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000						70.00
71.00	07100						71.00
73.00	07300						73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300						83.00
89.00		2,515,611	566,153		22,999	324,653	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
93.00	09300						93.00
94.00	09400						94.00
95.00	09500						95.00
98.00							98.00
99.00							99.00
100.00		2,515,611	566,153		22,999	324,653	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315039

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

Worksheet B
Part I
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE PATIENT 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	PATIENT ACTIVITIES	0	970,751			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	970,751	24,734,457	0	24,734,457 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	37,427	0	37,427 40.00
41.00 04100	LABORATORY	0	0	21,849	0	21,849 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	96,114	0	96,114 43.00
44.00 04400	PHYSICAL THERAPY	0	0	516,765	0	516,765 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	1,024,839	0	1,024,839 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	230,116	0	230,116 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	760,931	0	760,931 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
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					62.00
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
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
89.00	SUBTOTALS (sum of lines 1-84)	0	970,751	27,422,498	0	27,422,498 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	36,224	0	36,224 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	IDLE SPACE	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	970,751	27,458,722	0	27,458,722 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315039

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

Worksheet B
Part II
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDGS & FIXTURES	MOVABLE EQUIPMENT		
		0	2.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	174,720	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	31,986	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	33,382	0	6.00
7.00 00700	HOUSEKEEPING	0	10,945	0	7.00
8.00 00800	DIETARY	0	39,853	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	3,420	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	5,322	0	12.00
13.00 01300	SOCIAL SERVICE	0	7,388	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	0	54,834	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	SKILLED NURSING FACILITY	0	717,693	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00 04000	RADIOLOGY	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	10,753	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	10,753	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00 06000	CLINIC	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	61.00
62.00 06200	FOHC	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	71.00
73.00 07300	CMHC	0	0	0	73.00
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	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1,101,049	0	89.00
NONREIMBURSABLE COST CENTERS					
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	8,345	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	94.00
95.00 09500	IDLE SPACE	0	0	0	95.00
98.00	Cross Foot Adjustments				98.00
99.00	Negative Cost Centers				99.00
100.00	TOTAL	0	1,109,394	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315039		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/2/2024 10:05 am		
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	174,720				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	9,164	41,150			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	2,674	1,522	37,578		6.00	
7.00	00700	HOUSEKEEPING	8,430	499	0	19,874	7.00	
8.00	00800	DIETARY	19,418	1,817	0	923	62,011	8.00
9.00	00900	NURSING ADMINISTRATION	15,938	156	0	79	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	3,602	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	39	243	0	123	0	12.00
13.00	01300	SOCIAL SERVICE	1,917	337	0	171	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	5,074	2,500	0	1,270	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	93,412	32,716	37,578	16,617	62,011	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	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	238	0	0	0	0	40.00
41.00	04100	LABORATORY	139	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	612	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	3,072	490	0	249	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	6,305	490	0	249	0	45.00
46.00	04600	SPEECH PATHOLOGY	1,464	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	3,159	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
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
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
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
89.00		SUBTOTALS (sum of lines 1-84)	174,657	40,770	37,578	19,681	62,011	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	63	380	0	193	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	IDLE SPACE	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments			0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	174,720	41,150	37,578	19,874	62,011	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315039

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

Worksheet B
Part II
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	19,593					9.00
10.00	01000	0	3,602				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	5,727		12.00
13.00	01300	0	0	0	0	9,813	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,593	1,919	0	5,727	9,813	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	1,683	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		19,593	3,602	0	5,727	9,813	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		19,593	3,602	0	5,727	9,813	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315039

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

Worksheet B
Part II
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	Post Step-Down 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	PATIENT ACTIVITIES	0	63,678			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	63,678	1,060,757	0	1,060,757
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	238	0	238
41.00 04100	LABORATORY	0	0	139	0	139
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	612	0	612
44.00 04400	PHYSICAL THERAPY	0	0	14,564	0	14,564
45.00 04500	OCCUPATIONAL THERAPY	0	0	17,797	0	17,797
46.00 04600	SPEECH PATHOLOGY	0	0	1,464	0	1,464
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	4,842	0	4,842
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
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
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
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
89.00	SUBTOTALS (sum of lines 1-84)	0	63,678	1,100,413	0	1,100,413
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	8,981	0	8,981
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	IDLE SPACE	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	0	63,678	1,109,394	0	1,109,394

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315039

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

Worksheet B-1
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	81,090					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	8,773,945			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	12,771	0	755,644	-3,832,746	23,625,976	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	2,338	0	130,008	0	1,239,225	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	2,440	0	0	0	361,570	6.00
7.00 00700	HOUSEKEEPING	800	0	298,545	0	1,140,015	7.00
8.00 00800	DIETARY	2,913	0	1,096,624	0	2,625,865	8.00
9.00 00900	NURSING ADMINISTRATION	250	0	1,280,067	0	2,155,179	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	487,128	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	389	0	0	0	5,322	12.00
13.00 01300	SOCIAL SERVICE	540	0	159,444	0	259,254	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	4,008	0	389,635	0	686,189	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	52,459	0	4,663,978	0	12,630,956	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	0	32,203	40.00
41.00 04100	LABORATORY	0	0	0	0	18,799	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	82,698	43.00
44.00 04400	PHYSICAL THERAPY	786	0	0	0	415,402	44.00
45.00 04500	OCCUPATIONAL THERAPY	786	0	0	0	852,558	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	197,996	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	427,136	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
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
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
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
89.00	SUBTOTALS (sum of lines 1-84)	80,480	0	8,773,945	-3,832,746	23,617,495	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	610	0	0	0	8,481	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	IDLE SPACE	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)	1,109,394	0	5,085,815		3,832,746	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	13.681021	0.000000	0.579650		0.162226	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		174,720	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007395	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315039

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

Worksheet B-1

Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS HRS)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500	65,981					5.00
6.00	00600	2,440	59,659				6.00
7.00	00700	800	0	62,741			7.00
8.00	00800	2,913	0	2,913	178,977		8.00
9.00	00900	250	0	250	0	274,923	9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	389	0	389	0	0	12.00
13.00	01300	540	0	540	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	4,008	0	4,008	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	52,459	59,659	52,459	178,977	274,923	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	786	0	786	0	0	44.00
45.00	04500	786	0	786	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		65,371	59,659	62,131	178,977	274,923	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	610	0	610	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00		1,440,260	473,487	1,342,418	3,177,762	2,515,611	102.00
103.00		21.828405	7.936556	21.396184	17.755142	9.150238	103.00
104.00		41,150	37,578	19,874	62,011	19,593	104.00
105.00		0.623664	0.629880	0.316763	0.346475	0.071267	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315039

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

Worksheet B-1
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	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	914,264				10.00
11.00	01100	PHARMACY	0	0			11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	59,659		12.00
13.00	01300	SOCIAL SERVICE	0	0	0	59,659	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	487,128	0	59,659	59,659	0
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	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	0
41.00	04100	LABORATORY	0	0	0	0	0
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00	04400	PHYSICAL THERAPY	0	0	0	0	0
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	427,136	0	0	0	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	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	FOHC	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	0	0	0	0	0
73.00	07300	CMHC	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
89.00		SUBTOTALS (sum of lines 1-84)	914,264	0	59,659	59,659	0
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	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	IDLE SPACE	0	0	0	0	0
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)	566,153	0	22,999	324,653	0
103.00		Unit cost multiplier (Wkst. B, Part I)	0.619245	0.000000	0.385508	5.441811	0.000000
104.00		Cost to be allocated (per Wkst. B, Part II)	3,602	0	5,727	9,813	0
105.00		Unit cost multiplier (Wkst. B, Part II)	0.003940	0.000000	0.095996	0.164485	0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315039

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

Worksheet B-1

Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description		OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT_DAYS)	
	GENERAL SERVICE COST CENTERS	15.00	
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 PATIENT ACTIVITIES	59,659	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000 SKILLED NURSING FACILITY	59,659	30.00
31.00	03100 NURSING FACILITY	0	31.00
32.00	03200 ICF/IID	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	33.00
	ANCILLARY SERVICE COST CENTERS		
40.00	04000 RADIOLOGY	0	40.00
41.00	04100 LABORATORY	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400 PHYSICAL THERAPY	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100 SUPPORT SURFACES	0	51.00
	OUTPATIENT SERVICE COST CENTERS		
60.00	06000 CLINIC	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	61.00
62.00	06200 FOHC	0	62.00
	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
	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
89.00	SUBTOTALS (sum of lines 1-84)	59,659	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 IDLE SPACE	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)	970,751	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	16.271661	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	63,678	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	1.067366	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/2/2024 10:05 am		
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)		
		1.00	2.00	3.00		
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	37,427	16,515	2.266243	40.00
41.00	04100	LABORATORY	21,849	1,891	11.554204	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	96,114	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	516,765	727,263	0.710561	44.00
45.00	04500	OCCUPATIONAL THERAPY	1,024,839	917,025	1.117569	45.00
46.00	04600	SPEECH PATHOLOGY	230,116	286,518	0.803147	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	760,931	250,961	3.032069	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
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	FQHC				62.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	2,688,041	2,200,173		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/2/2024 10:05 am			
		Title XVIII (1)	Skilled Nursing Facility	PPS			
		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)		
Ratio of Cost to Charges (Fr. Wkst. C Column 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	2.266243	14,370	0	32,566	0	40.00
41.00	04100 LABORATORY	11.554204	1,891	0	21,849	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	0.710561	370,525	0	263,281	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	1.117569	372,598	0	416,404	0	45.00
46.00	04600 SPEECH PATHOLOGY	0.803147	164,631	0	132,223	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	3.032069	216,842	0	657,480	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0.000000	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC						61.00
62.00	06200 FQHC						62.00
71.00	07100 AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		1,140,857	0	1,523,803	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. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/2/2024 10:05 am
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST					
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		3.032069	1.00
2.00		Program vaccine charges (From your records, or the PS&R)		3,477	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		10,543	3.00

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

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	37,427	0	0.000000	32,566	0	40.00
41.00	04100	LABORATORY	21,849	0	0.000000	21,849	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	96,114	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	516,765	0	0.000000	263,281	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	1,024,839	0	0.000000	416,404	0	45.00
46.00	04600	SPEECH PATHOLOGY	230,116	0	0.000000	132,223	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	760,931	0	0.000000	657,480	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	2,688,041	0		1,523,803	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/2/2024 10:05 am
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		59,659	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		9,738	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		24,734,457	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		28,772,759	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.859648	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)		24,734,457	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		414.60	16.00
17.00	Program routine service cost (Line 3 times line 16)		4,037,375	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)		4,037,375	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)		1,060,757	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		17.78	21.00
22.00	Program capital related cost (Line 3 times line 21)		173,142	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		3,864,233	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)		3,864,233	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

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

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		59,659	1.00
2.00	Program inpatient days (see instructions)		9,738	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)		0.163228	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 XVIIII		Provider No. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/2/2024 10:05 am
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		7,591,667	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)		7,591,667	3.00
4.00	Primary payor amounts		3,904	4.00
5.00	Coinurance		1,289,400	5.00
6.00	Allowable bad debts (From your records)		274,662	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		125,669	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		178,530	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		6,476,893	11.00
12.00	Interim payments (See instructions)		6,378,594	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)		3,571	14.75
14.99	Sequestration amount (see instructions)		125,967	14.99
15.00	Balance due provider/program (see Instructions)		-31,239	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		10,543	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		10,543	19.00
20.00	Medicare Part B ancillary charges (See instructions)		3,477	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		3,477	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)		3,477	25.00
26.00	Interim payments (See instructions)		2,454	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)		70	28.99
29.00	Balance due provider/program (see instructions)		953	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. : 315039	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/2/2024 10:05 am	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		6,396,181		2,454
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)		0		0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/17/2023	17,587		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		-17,587		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		6,378,594		2,454
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	PROGRAM TO PROVIDER		0		953
6.02	PROVIDER TO PROGRAM		31,239		0
7.00	Total Medicare program liability (see instructions)		6,347,355		3,407
			Contractor Name		Contractor Number
			1.00	2.00	
8.00	Name of Contractor				

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

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

Provider No.: 315039

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

Worksheet G

Date/Time Prepared:
5/2/2024 10:05 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	3,907,630	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	5,172,520	0	0	0	4.00
5.00	Other receivables	-349,856	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	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)	8,730,294	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	21,972,610	0	0	0	15.00
16.00	Less Accumulated depreciation	-16,832,772	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	94,916	0	0	0	21.00
22.00	Less: Accumulated depreciation	-94,916	0	0	0	22.00
23.00	Major movable equipment	6,142,756	0	0	0	23.00
24.00	Less: Accumulated depreciation	-6,130,796	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	5,151,798	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	661,320	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	1,886,048	0	0	0	31.00
32.00	Other assets	0	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	2,547,368	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	16,429,460	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	-29,428,381	0	0	0	35.00
36.00	Salaries, wages, and fees payable	321,998	0	0	0	36.00
37.00	Payroll taxes payable	0	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	0	0	0	0	41.00
42.00	Other current liabilities	228,799,859	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	199,693,476	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	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)	0	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	199,693,476	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-183,264,016	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)	-183,264,016	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	16,429,460	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315039

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

Worksheet G-1

Date/Time Prepared:
5/2/2024 10:05 am

		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		-184,911,270		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-1,161,655			2.00
3.00	Total (sum of line 1 and line 2)		-186,072,925		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00	ADDITIONS	2,808,908		0		5.00
6.00	ROUNDING	1		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		2,808,909		0	10.00
11.00	Subtotal (line 3 plus line 10)		-183,264,016		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-183,264,016		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	ADDITIONS		0			5.00
6.00	ROUNDING		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			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. : 315039

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/2/2024 10:05 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	28,772,759		28,772,759	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)	28,772,759		28,772,759	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	2,200,173	0	2,200,173	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	ROUTINE CHARGES / BED HOLD	489,771	0	489,771	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	31,462,703	0	31,462,703	14.00
Cost Center Description					
			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			32,244,181	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)			32,244,181	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315039

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

Worksheet G-3

Date/Time Prepared:
5/2/2024 10:05 am

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	31,462,703	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,514,698	2.00
3.00	Net patient revenues (Line 1 minus line 2)	29,948,005	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	32,244,181	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-2,296,176	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	259,758	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	837,971	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	36,792	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	Other miscellaneous revenue (specify)	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	1,134,521	25.00
26.00	Total (Line 5 plus line 25)	-1,161,655	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)	-1,161,655	31.00