

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: 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/21/2024 3:41 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____ 6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERSIDE NURSING & REHAB (315235) 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	Daniel Bruckstein	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			2
3	Signatory Title			3
4	Date			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	86,179	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	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	86,179	0	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 3:41 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 325 JERSEY STREET	PO Box:				1.00		
2.00	City: TRENTON	State: NJ	Zip Code: 08611			2.00		
3.00	County: MERCER	CBSA Code: 45940	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
					4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	RIVERSIDE NURSING & REHAB	315235	03/26/1986	N	P	O	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00
				From:	To:			
14.00	Cost Reporting Period (mm/dd/yyyy)			1.00	2.00			
15.00	Type of Control (See Instructions)			01/01/2023	12/31/2023		14.00	
				4			15.00	
					Y/N			
					1.00			
Type of Freestanding Skilled Nursing Facility								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					Y	16.00	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	17.00	
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y	18.00	
Miscellaneous Cost Reporting Information								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					4,659	20.00	
21.00	Declining Balance					0	21.00	
22.00	Sum of the Year's Digits					0	22.00	
23.00	Sum of line 20 through 22					4,659	23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N	25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N	27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	28.00	
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility				N	N	N	29.00
30.00	Nursing Facility							30.00
31.00	ICF/IID							31.00
32.00	SNF-Based HHA				N	N		32.00
33.00	SNF-Based RHC							33.00
34.00	SNF-Based FQHC							34.00
35.00	SNF-Based CMHC					N		35.00
36.00	SNF-Based OLTC							36.00
				Y/N				
				1.00	2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)			Y			37.00	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)			Y			38.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.			1			39.00	
				Premiums	Paid Losses	Self Insurance		
				1.00	2.00	3.00		
41.00	List malpractice premiums and paid losses:			0	0	0	41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 3:41 pm
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		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:
46.00	Street:	PO Box:	
47.00	City:	State:	Zip Code:

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/21/2024 3:41 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		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	04/18/2024	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. : 315235

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/21/2024 3:41 pm

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

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

Provider No. : 315235

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/21/2024 3:41 pm

		Part B		
		Date		
		4.00		
PS&R Data				
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	04/18/2024		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.			18.00
			3.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE-PRESIDENT		19.00
20.00	Enter the employer/company name of the cost report preparer.			20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			21.00

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

Provider No. : 315235

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/21/2024 3:41 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	131	47,815	0	3,291	35,783	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)	131	47,815	0	3,291	35,783	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	7,977	47,051	0	56	88	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	7,977	47,051	0	56	88	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	57	201	0.00	58.77	406.63	1.00
2.00	NURSING FACILITY	0	0	0.00	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	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	57	201	0.00	58.77	406.63	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	234.08	0	66	62	87	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)	234.08	0	66	62	87	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	215	74.87	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)	215	74.87	0.00	8.00		

Provider No. : 315235

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

Worksheet S-3
Part II
Date/Time Prepared:
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	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)	5,305,328	0	5,305,328	155,727.00	34.07
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	5,305,328	0	5,305,328	155,727.00	34.07
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00
9.00	CMHC	0	0	0	0.00	0.00
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	5,305,328	0	5,305,328	155,727.00	34.07
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	860,696	0	860,696	30,819.00	27.93
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	956,203	0	956,203		
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)	956,203	0	956,203		

Provider No. : 315235

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

Worksheet S-3
Part III
Date/Time Prepared:
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		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES							
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	504,864	0	504,864	8,386.00	60.20	2.00
3.00	Plant Operation, Maintenance & Repairs	111,474	0	111,474	3,662.00	30.44	3.00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4.00
5.00	Housekeeping	0	0	0	0.00	0.00	5.00
6.00	Dietary	0	0	0	0.00	0.00	6.00
7.00	Nursing Administration	497,005	0	497,005	8,278.00	60.04	7.00
8.00	Central Services and Supply	31,855	0	31,855	1,220.00	26.11	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	2,588	0	2,588	951.00	2.72	10.00
11.00	Social Service	102,428	0	102,428	1,288.00	79.52	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	190,793	0	190,793	7,963.00	23.96	13.00
14.00	Total (sum lines 1 thru 13)	1,441,007	0	1,441,007	31,748.00	45.39	14.00

SNF WAGE RELATED COSTS	Provider No. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/21/2024 3:41 pm
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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	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	212,786	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	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	159,348	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	584,112	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	-43	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	956,203	24.00
		Amount Reported	
		1.00	
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315235

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

Worksheet S-3
Part V
Date/Time Prepared:
5/21/2024 3:41 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	568,465	104,062	672,527	9,245.00	72.74	1.00
2.00	Licensed Practical Nurses (LPNs)	1,433,848	262,477	1,696,325	29,794.00	56.94	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,523,084	278,812	1,801,896	79,878.00	22.56	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,525,397	645,351	4,170,748	118,917.00	35.07	4.00
5.00	Physical Therapists	211,137	38,650	249,787	3,204.00	77.96	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	88,343	16,172	104,515	1,240.00	84.29	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	37,440	6,854	44,294	619.00	71.56	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)	94,266		94,266	1,482.00	63.61	14.00
15.00	Licensed Practical Nurses (LPNs)	101,341		101,341	1,862.00	54.43	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	649,389		649,389	27,292.00	23.79	16.00
17.00	Total Nursing (sum of lines 14 through 16)	844,996		844,996	30,636.00	27.58	17.00
18.00	Physical Therapists	15,700		15,700	183.00	85.79	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	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. : 315235

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

Worksheet S-7
Date/Time Prepared:
5/21/2024 3:41 pm

		Group	Days	
		1.00	2.00	
1.00		RUX		1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00		RVL		4.00
5.00		RHX		5.00
6.00		RHL		6.00
7.00		RMX		7.00
8.00		RML		8.00
9.00		RLX		9.00
10.00		RUC		10.00
11.00		RUB		11.00
12.00		RUA		12.00
13.00		RVC		13.00
14.00		RVB		14.00
15.00		RVA		15.00
16.00		RHC		16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21.00		RMA		21.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00		ES3		24.00
25.00		ES2		25.00
26.00		ES1		26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30.00		HD1		30.00
31.00		HC2		31.00
32.00		HC1		32.00
33.00		HB2		33.00
34.00		HB1		34.00
35.00		LE2		35.00
36.00		LE1		36.00
37.00		LD2		37.00
38.00		LD1		38.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00		CE2		43.00
44.00		CE1		44.00
45.00		CD2		45.00
46.00		CD1		46.00
47.00		CC2		47.00
48.00		CC1		48.00
49.00		CB2		49.00
50.00		CB1		50.00
51.00		CA2		51.00
52.00		CA1		52.00
53.00		SE3		53.00
54.00		SE2		54.00
55.00		SE1		55.00
56.00		SSC		56.00
57.00		SSB		57.00
58.00		SSA		58.00
59.00		IB2		59.00
60.00		IB1		60.00
61.00		IA2		61.00
62.00		IA1		62.00
63.00		BB2		63.00
64.00		BB1		64.00
65.00		BA2		65.00
66.00		BA1		66.00
67.00		PE2		67.00
68.00		PE1		68.00
69.00		PD2		69.00
70.00		PD1		70.00
71.00		PC2		71.00
72.00		PC1		72.00
73.00		PB2		73.00
74.00		PB1		74.00
75.00		PA2		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315235

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

Worksheet S-7

Date/Time Prepared:
5/21/2024 3:41 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315235

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

Worksheet A
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1,757,018	1,757,018	0	1,757,018	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		109,144	109,144	0	109,144	2.00
3.00	00300	EMPLOYEE BENEFITS	0	971,180	971,180	0	971,180	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	504,864	2,449,526	2,954,390	0	2,954,390	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	111,474	450,124	561,598	0	561,598	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	228,840	228,840	0	228,840	6.00
7.00	00700	HOUSEKEEPING	0	348,022	348,022	0	348,022	7.00
8.00	00800	DIETARY	0	956,538	956,538	0	956,538	8.00
9.00	00900	NURSING ADMINISTRATION	497,005	66,057	563,062	0	563,062	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	31,855	85,774	117,629	0	117,629	10.00
11.00	01100	PHARMACY	0	17,939	17,939	0	17,939	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	2,588	0	2,588	0	2,588	12.00
13.00	01300	SOCIAL SERVICE	102,428	0	102,428	0	102,428	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	190,793	15,065	205,858	0	205,858	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	3,527,401	891,400	4,418,801	0	4,418,801	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	6,537	6,537	0	6,537	40.00
41.00	04100	LABORATORY	0	9,697	9,697	0	9,697	41.00
42.00	04200	INTRAVENOUS THERAPY	0	52,209	52,209	0	52,209	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	1,350	1,350	0	1,350	43.00
44.00	04400	PHYSICAL THERAPY	211,137	34,715	245,852	0	245,852	44.00
45.00	04500	OCCUPATIONAL THERAPY	88,343	0	88,343	0	88,343	45.00
46.00	04600	SPEECH PATHOLOGY	37,440	0	37,440	0	37,440	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	199,716	199,716	0	199,716	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	8,424	8,424	0	8,424	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)	5,305,328	8,659,275	13,964,603	0	13,964,603	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
100.00		TOTAL	5,305,328	8,659,275	13,964,603	0	13,964,603	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315235

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

Worksheet A
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-469,053	1,287,965	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	109,144	2.00
3.00	00300	EMPLOYEE BENEFITS	0	971,180	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	29,125	2,983,515	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	561,598	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	228,840	6.00
7.00	00700	HOUSEKEEPING	0	348,022	7.00
8.00	00800	DIETARY	0	956,538	8.00
9.00	00900	NURSING ADMINISTRATION	0	563,062	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	117,629	10.00
11.00	01100	PHARMACY	0	17,939	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	2,588	12.00
13.00	01300	SOCIAL SERVICE	0	102,428	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	205,858	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	4,418,801	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	6,537	40.00
41.00	04100	LABORATORY	0	9,697	41.00
42.00	04200	INTRAVENOUS THERAPY	0	52,209	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	1,350	43.00
44.00	04400	PHYSICAL THERAPY	0	245,852	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	88,343	45.00
46.00	04600	SPEECH PATHOLOGY	0	37,440	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	199,716	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	8,424	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)	-439,928	13,524,675	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	0	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
100.00		TOTAL	-439,928	13,524,675	100.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315235

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

Worksheet A-7

Date/Time Prepared:
5/21/2024 3:41 pm

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	0	0	0	0	0	3.00
4.00 Building Improvements	1,105,831	0	0	0	1,067,349	4.00
5.00 Fixed Equipment	0	10,365	0	10,365	0	5.00
6.00 Movable Equipment	179,275	0	0	0	103,228	6.00
7.00 Subtotal (sum of lines 1-6)	1,285,106	10,365	0	10,365	1,170,577	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	1,285,106	10,365	0	10,365	1,170,577	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	0	0				
4.00 Building Improvements	38,482	0				
5.00 Fixed Equipment	10,365	0				
6.00 Movable Equipment	76,047	0				
7.00 Subtotal (sum of lines 1-6)	124,894	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	124,894	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315235

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

Worksheet A-8

Date/Time Prepared:
5/21/2024 3:41 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line No.
			1.00	2.00	3.00
1.00 Investment income on restricted funds (chapter 2)	B	-3,914	ADMINISTRATIVE & GENERAL	4.00	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	64,170			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	B	-6	ADMINISTRATIVE & GENERAL	4.00	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 P/R MARKETING DIRECTOR	A	-41,227	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01 PTO MARKETING DIRECTOR	A	-698	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02 PENALTIES	A	-11,032	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03 MCR COINSURANCE BAD DEBT EXPENSE	A	-42,920	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04 BAD DEBT EXPENSE	A	-28,000	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05 ADVERTISING & PROMOTION	A	-25	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06 MARKETING	A	-82,905	ADMINISTRATIVE & GENERAL	4.00	25.06
25.07 FED./STATE/LOCAL/MISC FEE	A	-71,997	ADMINISTRATIVE & GENERAL	4.00	25.07
25.08 PRIOR YEAR EXPENSE ADJ	A	-42,835	ADMINISTRATIVE & GENERAL	4.00	25.08
25.09 MEALS AND ENTERTAINMENT	A	-358	ADMINISTRATIVE & GENERAL	4.00	25.09
25.10 LATE FEES	A	-123	ADMINISTRATIVE & GENERAL	4.00	25.10
25.11 BAD DEBT EXPENSE	A	-60,110	ADMINISTRATIVE & GENERAL	4.00	25.11
25.12 CHARITABLE DONATIONS	A	-500	ADMINISTRATIVE & GENERAL	4.00	25.12
25.13 ADVERTISING & MARKETING	A	-18,208	ADMINISTRATIVE & GENERAL	4.00	25.13
25.14 MISC EXPENSE	A	-1,134	ADMINISTRATIVE & GENERAL	4.00	25.14
25.15 RESIDENT INCIDENTALS	A	-73	ADMINISTRATIVE & GENERAL	4.00	25.15
25.16 OTHER MISC INC	B	-16,813	ADMINISTRATIVE & GENERAL	4.00	25.16
25.17 OTHER INCOME	B	-81,220	ADMINISTRATIVE & GENERAL	4.00	25.17
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-439,928			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. : 315235

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/21/2024 3:41 pm

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT EXPENSE	1.00	
2.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	2.00	
3.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	REAL ESTATE TAX	3.00	
4.00	4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	4.00	
5.00	4.00	ADMINISTRATIVE & GENERAL	REALTY ADMIN	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		0	284,529	-284,529	1.00
2.00		791,205	975,729	-184,524	2.00
3.00		173,894	173,894	0	3.00
4.00		836,284	304,630	531,654	4.00
5.00		1,569	0	1,569	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.			64,170	10.00

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

Provider No. : 315235

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/21/2024 3:41 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	A	DANIEL BRUCKSTEIN	56.00	1.00
2.00	A	AKIKO IKE	13.00	2.00
3.00	A	MB HEALTHCARE LLC	7.00	3.00
4.00	A	ROBERT BRUCKSTEIN	6.00	4.00
5.00	A	TERRY LICHSCHIEIN	8.00	5.00
6.00	A	ESTHER FARKOWITZ	4.00	6.00
7.00	A	BENJAMIN LANDA	6.00	7.00
8.00	A	DANIEL BRUCKSTEIN	56.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
10.45			0.00	10.45
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	BELMAR REALTY LLC	56.00	REAL ESTATE	1.00
2.00	BELMAR REALTY LLC	13.00	REAL ESTATE	2.00
3.00	BELMAR REALTY LLC	7.00	REAL ESTATE	3.00
4.00	BELMAR REALTY LLC	6.00	REAL ESTATE	4.00
5.00	BELMAR REALTY LLC	8.00	REAL ESTATE	5.00
6.00	BELMAR REALTY LLC	4.00	REAL ESTATE	6.00
7.00	BELMAR REALTY LLC	6.00	REAL ESTATE	7.00
8.00	CONTINUUM HEALTHCARE LLC	81.00	MANAGEMENT	8.00
9.00		0.00		9.00
10.00		0.00		10.00
10.45		0.00		10.45
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. : 315235

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,287,965	1,287,965			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	109,144		109,144		2.00
3.00 00300	EMPLOYEE BENEFITS	971,180	0	0	971,180	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,983,515	187,691	15,905	92,419	3,279,530 4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	561,598	80,722	6,840	20,406	669,566 5.00
6.00 00600	LAUNDRY & LINEN SERVICE	228,840	36,123	3,061	0	268,024 6.00
7.00 00700	HOUSEKEEPING	348,022	14,303	1,212	0	363,537 7.00
8.00 00800	DIETARY	956,538	99,384	8,422	0	1,064,344 8.00
9.00 00900	NURSING ADMINISTRATION	563,062	0	0	90,980	654,042 9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	117,629	176,636	14,968	5,831	315,064 10.00
11.00 01100	PHARMACY	17,939	0	0	0	17,939 11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	2,588	5,094	432	474	8,588 12.00
13.00 01300	SOCIAL SERVICE	102,428	6,451	547	18,750	128,176 13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0 14.00
15.00 01500	ACTIVITIES	205,858	57,833	4,901	34,926	303,518 15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	4,418,801	529,416	44,864	645,718	5,638,799 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	6,537	0	0	0	6,537 40.00
41.00 04100	LABORATORY	9,697	0	0	0	9,697 41.00
42.00 04200	INTRAVENOUS THERAPY	52,209	0	0	0	52,209 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	1,350	0	0	0	1,350 43.00
44.00 04400	PHYSICAL THERAPY	245,852	46,711	3,958	38,650	335,171 44.00
45.00 04500	OCCUPATIONAL THERAPY	88,343	26,292	2,228	16,172	133,035 45.00
46.00 04600	SPEECH PATHOLOGY	37,440	5,361	454	6,854	50,109 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,897	754	0	9,651 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	199,716	7,051	598	0	207,365 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	FQHC	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	8,424	0	0	0	8,424 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)	13,524,675	1,287,965	109,144	971,180	13,524,675 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
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	13,524,675	1,287,965	109,144	971,180	13,524,675 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315235

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	3,279,530				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	214,332	883,898			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	85,796	31,317	385,137		6.00	
7.00	00700	HOUSEKEEPING	116,370	12,400	0	492,307	7.00	
8.00	00800	DIETARY	340,703	86,161	0	50,486	1,541,694	8.00
9.00	00900	NURSING ADMINISTRATION	209,363	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	100,854	153,134	0	89,729	0	10.00
11.00	01100	PHARMACY	5,742	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	2,749	4,416	0	2,588	0	12.00
13.00	01300	SOCIAL SERVICE	41,030	5,592	0	3,277	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	97,158	50,138	0	29,379	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,805,012	458,976	385,137	268,938	1,541,694	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	2,093	0	0	0	0	40.00
41.00	04100	LABORATORY	3,104	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	16,712	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	432	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	107,290	40,496	0	23,729	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	42,585	22,794	0	13,356	0	45.00
46.00	04600	SPEECH PATHOLOGY	16,040	4,647	0	2,723	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,089	7,714	0	4,520	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	66,379	6,113	0	3,582	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	2,697	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)	3,279,530	883,898	385,137	492,307	1,541,694	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
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	3,279,530	883,898	385,137	492,307	1,541,694	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315235

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	863,405					9.00
10.00	01000	0	658,781				10.00
11.00	01100	0	0	23,681			11.00
12.00	01200	0	0	0	18,341		12.00
13.00	01300	0	0	0	0	178,075	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	863,405	658,781	23,681	18,341	178,075	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
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		863,405	658,781	23,681	18,341	178,075	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
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00	TOTAL	863,405	658,781	23,681	18,341	178,075	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315235

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	480,193			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	480,193	12,321,032	0	12,321,032
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	8,630	0	8,630
41.00 04100	LABORATORY	0	0	12,801	0	12,801
42.00 04200	INTRAVENOUS THERAPY	0	0	68,921	0	68,921
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	1,782	0	1,782
44.00 04400	PHYSICAL THERAPY	0	0	506,686	0	506,686
45.00 04500	OCCUPATIONAL THERAPY	0	0	211,770	0	211,770
46.00 04600	SPEECH PATHOLOGY	0	0	73,519	0	73,519
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	24,974	0	24,974
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	283,439	0	283,439
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	11,121	0	11,121
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	480,193	13,524,675	0	13,524,675
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
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	480,193	13,524,675	0	13,524,675

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315235

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	187,691	15,905	203,596	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	80,722	6,840	87,562	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	36,123	3,061	39,184	6.00
7.00 00700	HOUSEKEEPING	0	14,303	1,212	15,515	7.00
8.00 00800	DIETARY	0	99,384	8,422	107,806	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	176,636	14,968	191,604	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	5,094	432	5,526	12.00
13.00 01300	SOCIAL SERVICE	0	6,451	547	6,998	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	0	57,833	4,901	62,734	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	529,416	44,864	574,280	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	46,711	3,958	50,669	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	26,292	2,228	28,520	45.00
46.00 04600	SPEECH PATHOLOGY	0	5,361	454	5,815	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,897	754	9,651	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	7,051	598	7,649	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	FOHC	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)	0	1,287,965	109,144	1,397,109	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments				0	98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	1,287,965	109,144	1,397,109	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315235

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	203,596				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	13,306	100,868			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	5,326	3,574	48,084		6.00	
7.00	00700	HOUSEKEEPING	7,224	1,415	0	24,154	7.00	
8.00	00800	DIETARY	21,151	9,832	0	2,477	141,266	8.00
9.00	00900	NURSING ADMINISTRATION	12,997	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	6,261	17,475	0	4,402	0	10.00
11.00	01100	PHARMACY	356	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	171	504	0	127	0	12.00
13.00	01300	SOCIAL SERVICE	2,547	638	0	161	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	6,032	5,722	0	1,441	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	112,057	52,378	48,084	13,195	141,266	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	130	0	0	0	0	40.00
41.00	04100	LABORATORY	193	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	1,037	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	27	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	6,661	4,621	0	1,164	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	2,644	2,601	0	655	0	45.00
46.00	04600	SPEECH PATHOLOGY	996	530	0	134	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	192	880	0	222	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	4,121	698	0	176	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	167	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)	203,596	100,868	48,084	24,154	141,266	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	203,596	100,868	48,084	24,154	141,266	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315235

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	12,997					9.00
10.00	01000	0	219,742				10.00
11.00	01100	0	0	356			11.00
12.00	01200	0	0	0	6,328		12.00
13.00	01300	0	0	0	0	10,344	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	12,997	219,742	356	6,328	10,344	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
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		12,997	219,742	356	6,328	10,344	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
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00	TOTAL	12,997	219,742	356	6,328	10,344	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315235

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	75,929			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	75,929	1,266,956	0	1,266,956
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	130	0	130
41.00 04100	LABORATORY	0	0	193	0	193
42.00 04200	INTRAVENOUS THERAPY	0	0	1,037	0	1,037
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	27	0	27
44.00 04400	PHYSICAL THERAPY	0	0	63,115	0	63,115
45.00 04500	OCCUPATIONAL THERAPY	0	0	34,420	0	34,420
46.00 04600	SPEECH PATHOLOGY	0	0	7,475	0	7,475
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10,945	0	10,945
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	12,644	0	12,644
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	167	0	167
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	75,929	1,397,109	0	1,397,109
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
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	75,929	1,397,109	0	1,397,109

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315235

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

Worksheet B-1
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	57,903					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		57,903				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	5,305,328			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	8,438	8,438	504,864	-3,279,530	10,245,145	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	3,629	3,629	111,474	0	669,566	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,624	1,624	0	0	268,024	6.00
7.00 00700	HOUSEKEEPING	643	643	0	0	363,537	7.00
8.00 00800	DIETARY	4,468	4,468	0	0	1,064,344	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	497,005	0	654,042	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	7,941	7,941	31,855	0	315,064	10.00
11.00 01100	PHARMACY	0	0	0	0	17,939	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	229	229	2,588	0	8,588	12.00
13.00 01300	SOCIAL SERVICE	290	290	102,428	0	128,176	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	2,600	2,600	190,793	0	303,518	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	23,801	23,801	3,527,401	0	5,638,799	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	6,537	40.00
41.00 04100	LABORATORY	0	0	0	0	9,697	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	52,209	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	1,350	43.00
44.00 04400	PHYSICAL THERAPY	2,100	2,100	211,137	0	335,171	44.00
45.00 04500	OCCUPATIONAL THERAPY	1,182	1,182	88,343	0	133,035	45.00
46.00 04600	SPEECH PATHOLOGY	241	241	37,440	0	50,109	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	400	400	0	0	9,651	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	317	317	0	0	207,365	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	8,424	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)	57,903	57,903	5,305,328	-3,279,530	10,245,145	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
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)	1,287,965	109,144	971,180		3,279,530	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	22.243493	1.884946	0.183057		0.320106	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		203,596	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019872	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315235

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

Worksheet B-1

Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	45,836					6.00
7.00	00700	1,624	47,051				7.00
8.00	00800	643	0	43,569			8.00
9.00	00900	4,468	0	4,468	141,153		9.00
10.00	01000	0	0	0	0	47,051	10.00
11.00	01100	7,941	0	7,941	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	229	0	229	0	0	13.00
14.00	01400	290	0	290	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.00	01500	2,600	0	2,600	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	23,801	47,051	23,801	141,153	47,051	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	2,100	0	2,100	0	0	44.00
45.00	04500	1,182	0	1,182	0	0	45.00
46.00	04600	241	0	241	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	400	0	400	0	0	48.00
49.00	04900	317	0	317	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		45,836	47,051	43,569	141,153	47,051	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
98.00							98.00
99.00							99.00
102.00		883,898	385,137	492,307	1,541,694	863,405	102.00
103.00		19.283925	8.185522	11.299479	10.922148	18.350407	103.00
104.00		100,868	48,084	24,154	141,266	12,997	104.00
105.00		2.200628	1.021955	0.554385	1.000801	0.276232	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315235

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

Worksheet B-1

Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	47,051					10.00
11.00	01100	0	47,051				11.00
12.00	01200	0	0	47,051			12.00
13.00	01300	0	0	0	47,051		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	47,051	47,051	47,051	47,051	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
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		47,051	47,051	47,051	47,051	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		658,781	23,681	18,341	178,075	0	102.00
103.00		14.001424	0.503305	0.389811	3.784723	0.000000	103.00
104.00		219,742	356	6,328	10,344	0	104.00
105.00		4.670294	0.007566	0.134492	0.219847	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315235

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

Worksheet B-1
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		OTHER GENERAL SERVICE		
		ACTIVITIES (PATIENT DAYS)		
		15.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500	ACTIVITIES	47,051	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	47,051	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)	47,051	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
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)	480,193	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	10.205798	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	75,929	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	1.613760	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315235

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

Worksheet C
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
			Wkst. B, Pt 1, col. 18)		divided by col. 2	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	8,630	6,537	1.320177	40.00
41.00	04100	LABORATORY	12,801	9,697	1.320099	41.00
42.00	04200	INTRAVENOUS THERAPY	68,921	52,209	1.320098	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	1,782	1,350	1.320000	43.00
44.00	04400	PHYSICAL THERAPY	506,686	245,852	2.060939	44.00
45.00	04500	OCCUPATIONAL THERAPY	211,770	96,799	2.187729	45.00
46.00	04600	SPEECH PATHOLOGY	73,519	122,197	0.601643	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,974	0	0.000000	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	283,439	199,716	1.419210	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	11,121	8,424	1.320157	71.00
100.00		Total	1,203,643	742,781		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315235		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part I Date/Time Prepared: 5/21/2024 3:41 pm	
		Title XVIII (1)		Skilled Nursing Facility		PPS	
		Health Care Program Charges		Health Care Program Cost			
		Ratio of Cost to Charges (Fr. Wkst. C Column 3)		Part A (col. 1 x col. 2)		Part B (col. 1 x col. 3)	
		1.00		2.00		3.00	
		1.00		2.00		3.00	
		1.00		2.00		3.00	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	1.320177	0	0	0	0 40.00
41.00	04100	LABORATORY	1.320099	0	0	0	0 41.00
42.00	04200	INTRAVENOUS THERAPY	1.320098	0	0	0	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	1.320000	0	0	0	0 43.00
44.00	04400	PHYSICAL THERAPY	2.060939	143,157	0	295,038	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	2.187729	70,529	0	154,298	0 45.00
46.00	04600	SPEECH PATHOLOGY	0.601643	100,601	0	60,526	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	1.419210	2,240	0	3,179	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)	1.320157		0		0 71.00
100.00		Total (Sum of lines 40 - 71)		316,527	0	513,041	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. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/21/2024 3:41 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description			1.00	
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PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.419210	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	0	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)	0	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	8,630	0	0.000000	0	0 40.00
41.00	04100	LABORATORY	12,801	0	0.000000	0	0 41.00
42.00	04200	INTRAVENOUS THERAPY	68,921	0	0.000000	0	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	1,782	0	0.000000	0	0 43.00
44.00	04400	PHYSICAL THERAPY	506,686	0	0.000000	295,038	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	211,770	0	0.000000	154,298	0 45.00
46.00	04600	SPEECH PATHOLOGY	73,519	0	0.000000	60,526	0 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0 47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,974	0	0.000000	0	0 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	283,439	0	0.000000	3,179	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)	1,192,522	0		513,041	0 100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/21/2024 3:41 pm
	Title XVIII	Skilled Nursing Facility	PPS

	1.00	
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PART I CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1.00	Inpatient days including private room days	47,051	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	3,291	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	12,321,032	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	14,165,477	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.869793	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)	12,321,032	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	261.87	16.00
17.00	Program routine service cost (Line 3 times line 16)	861,814	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)	861,814	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)	1,266,956	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	26.93	21.00
22.00	Program capital related cost (Line 3 times line 21)	88,627	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	773,187	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)	773,187	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	
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PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days	47,051	1.00
2.00	Program inpatient days (see instructions)	3,291	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)	0.069945	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/21/2024 3:41 pm
	Title XIX	Skilled Nursing Facility	Cost

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		47,051	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		35,783	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		12,321,032	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		14,165,477	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.869793	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		9,469,556	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		201.26	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)		12,321,032	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		261.87	16.00
17.00	Program routine service cost (Line 3 times line 16)		9,370,494	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)		9,370,494	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)		1,266,956	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		26.93	21.00
22.00	Program capital related cost (Line 3 times line 21)		963,636	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		8,406,858	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)		8,406,858	25.00
26.00	Enter the per diem limitation (1)		0.00	26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		0	27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		9,370,494	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		47,051	1.00
2.00	Program inpatient days (see instructions)		35,783	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)		0.760515	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. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/21/2024 3:41 pm
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		2,071,494	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)		2,071,494	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		430,200	5.00
6.00	Allowable bad debts (From your records)		280,134	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		157,750	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		182,087	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)		1,823,381	11.00
12.00	Interim payments (See instructions)		1,700,734	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)		3,642	14.75
14.99	Sequestration amount (see instructions)		32,826	14.99
15.00	Balance due provider/program (see Instructions)		86,179	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)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315235	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part II Date/Time Prepared: 5/21/2024 3:41 pm
		Title XIX	Skilled Nursing Facility	Cost
				1.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		9,370,494	4.00
5.00	Utilization review--physicians' compensation (from provider records)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)		9,370,494	6.00
7.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		9,370,494	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		9,370,494	10.00
REASONABLE CHARGES				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315235

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

Worksheet E-1

Date/Time Prepared:
5/21/2024 3:41 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		1,608,468 92,266			0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0			0 3.01
3.02			0			0 3.02
3.03			0			0 3.03
3.04			0			0 3.04
3.05			0			0 3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0			0 3.50
3.51			0			0 3.51
3.52			0			0 3.52
3.53			0			0 3.53
3.54			0			0 3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		1,700,734			0 4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0			0 5.01
5.02			0			0 5.02
5.03			0			0 5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0			0 5.50
5.51			0			0 5.51
5.52			0			0 5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0			0 5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					0 6.00
6.01	PROGRAM TO PROVIDER		86,179			0 6.01
6.02	PROVIDER TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		1,786,913			0 7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor					0 8.00

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

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

Provider No. : 315235

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

Worksheet G

Date/Time Prepared:
5/21/2024 3:41 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	28,488	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	1,675,542	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-60,110	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	200,931	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)	1,844,851	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	38,482	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	10,365	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	76,047	0	0	0	23.00
24.00	Less: Accumulated depreciation	-4,659	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	2,525	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	122,760	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	93,043	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	93,043	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	2,060,654	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,269,528	0	0	0	35.00
36.00	Salaries, wages, and fees payable	159,662	0	0	0	36.00
37.00	Payroll taxes payable	49,236	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	691,303	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2,169,729	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)	2,169,729	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-109,075	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)	-109,075	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	2,060,654	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315235

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

Worksheet G-1

Date/Time Prepared:
5/21/2024 3:41 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,886,529			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		370,899				2.00
3.00	Total (sum of line 1 and line 2)		-1,515,630			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	CAP	1,406,555			0	0	5.00
6.00		0			0	0	6.00
7.00		0			0	0	7.00
8.00		0			0	0	8.00
9.00		0			0	0	9.00
10.00	Total additions (sum of line 5 - 9)		1,406,555			0	10.00
11.00	Subtotal (line 3 plus line 10)		-109,075			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-109,075			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	CAP		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 5 - 9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)						12.00
13.00			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. : 315235

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/21/2024 3:41 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	14,165,477		14,165,477	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)	14,165,477		14,165,477	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	742,781	0	742,781	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	14,908,258	0	14,908,258	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			13,964,603	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)			13,964,603	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315235

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

Worksheet G-3

Date/Time Prepared:
5/21/2024 3:41 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	14,908,258	1.00
2.00	Less: contractual allowances and discounts on patients accounts	674,709	2.00
3.00	Net patient revenues (Line 1 minus line 2)	14,233,549	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	13,964,603	4.00
5.00	Net income from service to patients (Line 3 minus 4)	268,946	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,914	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC INCOME	16,813	24.00
24.01	OTHER INCOME	81,220	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	101,953	25.00
26.00	Total (Line 5 plus line 25)	370,899	26.00
27.00		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)	370,899	31.00