

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: 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 11:45 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT RIDGEWOOD AVENUE (315426) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-70,683	-746	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	-70,683	-746	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. : 315426		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 11:45 am				
1.00		2.00		3.00						
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:										
1.00	Street: 90 W. RIDGEWOOD	PO Box:						1.00		
2.00	City: PARAMUS	State: NJ		Zip Code: 07652				2.00		
3.00	County: BERGEN	CBSA Code: 35614		Urban/Rural: U				3.00		
3.01		CBSA Code:						3.01		
		Component Name		Provider CCN	Date Certified	Payment System (P, 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	CARE ONE AT RIDGEWOOD AVENUE		315426	05/26/1998	N	P	N	4.00	
5.00	Nursing Facility								5.00	
6.00	ICF/IID								6.00	
7.00	SNF-Based HHA								7.00	
8.00	SNF-Based RHC								8.00	
9.00	SNF-Based 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:				
					1.00	2.00				
14.00	Cost Reporting Period (mm/dd/yyyy)				01/01/2023	12/31/2023		14.00		
15.00	Type of Control (See Instructions)				4		15.00			
					Y/N					
					1.00					
Type of Freestanding Skilled Nursing Facility										
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						Y		16.00	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						N		17.00	
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.						Y		18.00	
Miscellaneous Cost Reporting Information										
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.						N		19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.						N		19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.										
20.00	Straight Line						666,987		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						666,987		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)						N		37.00	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)						Y		38.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.						1		39.00	
				Premiums	Paid Losses	Self Insurance				
				1.00	2.00	3.00				
41.00	List malpractice premiums and paid losses:				61,500	0	0		41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/10/2024 11:45 am
				Y/N
				1.00
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N 42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			Y 43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			HB0206 44.00
	1.00	2.00	3.00	
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.				
45.00	Name: HEALTHBRIDGE	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 12001	45.00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:		46.00
47.00	City: FORT LEE	State: NJ	Zip Code: 07024	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/10/2024 11:45 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)		N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.		N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.		N		8.00
			Y/N		
			1.00		
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
			Part A		Part B
			Description	Y/N	Date
			0	1.00	2.00
					3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		Y	03/19/2024	Y
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
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
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
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
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		N		N

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

Provider No. : 315426

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/10/2024 11:45 am

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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. : 315426

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/10/2024 11:45 am

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

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

Provider No. : 315426

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/10/2024 11:45 am

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	110	40,150	0	18,793	0	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)	110	40,150	0	18,793	0	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	13,646	32,439	0	578	0	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)	13,646	32,439	0	578	0	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	519	1,097	0.00	32.51	0.00	1.00
2.00	NURSING FACILITY	0	0	0.00	0	0.00	2.00
3.00	ICF/IID	0	0	0.00	0	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0	0.00	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	519	1,097	0.00	32.51	0.00	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX		Other
		16.00	17.00	18.00	19.00		20.00
1.00	SKILLED NURSING FACILITY	29.57	0	614	0	484	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)	29.57	0	614	0	484	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	1,098	153.69	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)	1,098	153.69	0.00	8.00		

Provider No. : 315426

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

Worksheet S-3
Part II
Date/Time Prepared:
5/10/2024 11:45 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	10,973,686	0	10,973,686	319,684.00	34.33 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	10,973,686	0	10,973,686	319,684.00	34.33 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	10,973,686	0	10,973,686	319,684.00	34.33 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	264,955	0	264,955	3,787.00	69.96 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1,841,766	0	1,841,766		
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)	1,841,766	0	1,841,766		

Provider No. : 315426

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

Worksheet S-3
Part III
Date/Time Prepared:
5/10/2024 11:45 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	705,387	0	705,387	16,640.00	2.00
3.00	Plant Operation, Maintenance & Repairs	175,830	0	175,830	6,115.00	3.00
4.00	Laundry & Linen Service	74,107	0	74,107	3,879.00	4.00
5.00	Housekeeping	353,297	0	353,297	20,306.00	5.00
6.00	Dietary	578,017	0	578,017	25,585.00	6.00
7.00	Nursing Administration	1,027,832	0	1,027,832	24,368.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	39,871	0	39,871	1,907.00	10.00
11.00	Social Service	114,221	0	114,221	3,724.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	173,361	0	173,361	7,978.00	13.00
14.00	Total (sum lines 1 thru 13)	3,241,923	0	3,241,923	110,502.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/10/2024 11:45 am
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			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		53,198	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)		703,150	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		2,210	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		169,078	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		798,686	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		115,444	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)		1,841,766	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. : 315426

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

Worksheet S-3
Part V
Date/Time Prepared:
5/10/2024 11:45 am

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	1,129,732	204,028	1,333,760	24,214.00	55.08	1.00
2.00	Licensed Practical Nurses (LPNs)	1,443,429	260,681	1,704,110	35,697.00	47.74	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,711,915	309,170	2,021,085	72,939.00	27.71	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4,285,076	773,879	5,058,955	132,850.00	38.08	4.00
5.00	Physical Therapists	1,582,306	285,762	1,868,068	36,750.00	50.83	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	1,423,479	257,079	1,680,558	33,632.00	49.97	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	268,381	48,469	316,850	5,309.00	59.68	11.00
12.00	Respiratory Therapists	43,659	7,885	51,544	640.00	80.54	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)	115,158		115,158	1,386.00	83.09	14.00
15.00	Licensed Practical Nurses (LPNs)	89,804		89,804	1,214.00	73.97	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	57,555		57,555	1,151.00	50.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	262,517		262,517	3,751.00	69.99	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	1,930		1,930	26.00	74.23	24.00
25.00	Respiratory Therapists	508		508	10.00	50.80	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315426

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

Worksheet S-7

Date/Time Prepared:
5/10/2024 11:45 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315426

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

Worksheet S-7

Date/Time Prepared:
5/10/2024 11:45 am

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/10/2024 11:45 am
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)
	1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES		3,251,154	0	3,251,154
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		297,733	0	297,733
3.00 00300	EMPLOYEE BENEFITS	0	1,981,834	0	1,981,834
4.00 00400	ADMINISTRATIVE & GENERAL	705,387	2,448,210	0	3,153,597
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	175,830	703,972	0	879,802
6.00 00600	LAUNDRY & LINEN SERVICE	74,107	59,907	0	134,014
7.00 00700	HOUSEKEEPING	353,297	72,324	0	425,621
8.00 00800	DIETARY	578,017	339,746	0	917,763
9.00 00900	NURSING ADMINISTRATION	1,027,832	177,917	0	1,205,749
10.00 01000	CENTRAL SERVICES & SUPPLY	0	251,500	0	251,500
11.00 01100	PHARMACY	0	13,736	0	13,736
12.00 01200	MEDICAL RECORDS & LIBRARY	39,871	0	0	39,871
13.00 01300	SOCIAL SERVICE	114,221	0	0	114,221
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0
15.00 01500	ACTIVITIES	173,361	7,401	0	180,762
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	SKILLED NURSING FACILITY	4,328,735	331,709	0	4,660,444
31.00 03100	NURSING FACILITY	0	0	0	0
32.00 03200	ICF/IID	0	0	0	0
33.00 03300	OTHER LONG TERM CARE	0	0	0	0
ANCILLARY SERVICE COST CENTERS					
40.00 04000	RADIOLOGY	0	102,404	0	102,404
41.00 04100	LABORATORY	0	197,459	0	197,459
42.00 04200	INTRAVENOUS THERAPY	0	268,408	0	268,408
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0
44.00 04400	PHYSICAL THERAPY	1,711,168	76,810	0	1,787,978
45.00 04500	OCCUPATIONAL THERAPY	1,423,479	27	0	1,423,506
46.00 04600	SPEECH PATHOLOGY	268,381	1,930	0	270,311
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
49.00 04900	DRUGS CHARGED TO PATIENTS	0	832,421	0	832,421
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0
51.00 05100	SUPPORT SURFACES	0	0	0	0
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0
52.02 05202	MEDICAL SERVICES	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
60.00 06000	CLINIC	0	0	0	0
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0
62.00 06200	FQHC	0	0	0	0
63.00 06300	DIALYSIS	0	0	0	0
OTHER REIMBURSABLE COST CENTERS					
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0
71.00 07100	AMBULANCE	0	49,954	0	49,954
73.00 07300	CMHC	0	0	0	0
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0
81.00 08100	INTEREST EXPENSE	0	0	0	0
82.00 08200	UTILIZATION REVIEW - SNF	0	0	0	0
83.00 08300	HOSPICE	0	0	0	0
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0
89.00	SUBTOTALS (sum of lines 1-84)	10,973,686	11,466,556	0	22,440,242
NONREIMBURSABLE COST CENTERS					
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	4,771	0	4,771
91.00 09100	BARBER AND BEAUTY SHOP	0	10,427	0	10,427
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0
93.00 09300	NONPAID WORKERS	0	0	0	0
94.00 09400	PATIENTS LAUNDRY	0	0	0	0
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0
100.00	TOTAL	10,973,686	11,481,754	0	22,455,440

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/10/2024 11:45 am
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Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-3,084	3,248,070	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	297,733	2.00
3.00	00300	EMPLOYEE BENEFITS	0	1,981,834	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-876,332	2,277,265	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	879,802	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	-3,099	130,915	6.00
7.00	00700	HOUSEKEEPING	0	425,621	7.00
8.00	00800	DIETARY	0	917,763	8.00
9.00	00900	NURSING ADMINISTRATION	-3,597	1,202,152	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	251,500	10.00
11.00	01100	PHARMACY	-1,099	12,637	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	39,871	12.00
13.00	01300	SOCIAL SERVICE	0	114,221	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	180,762	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-18,981	4,641,463	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	102,404	40.00
41.00	04100	LABORATORY	0	197,459	41.00
42.00	04200	INTRAVENOUS THERAPY	-21,473	246,935	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	1,787,978	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	1,423,506	45.00
46.00	04600	SPEECH PATHOLOGY	0	270,311	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	-66,594	765,827	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	52.02
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FQHC	0	0	62.00
63.00	06300	DIALYSIS	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	49,954	71.00
73.00	07300	CMHC	0	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	-994,259	21,445,983	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	4,771	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	10,427	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	95.00
100.00		TOTAL	-994,259	21,461,181	100.00

Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/10/2024 11:45 am
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		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Recl assi fi cations (Sum of col umns 4 and 5 must equal sum of col umns 8 and 9)				0	0 100.00

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

Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/10/2024 11:45 am
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		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
100.00	TOTALS			0	0	100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315426

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

Worksheet A-7

Date/Time Prepared:
5/10/2024 11:45 am

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,064,000	0	0	0	1.00
2.00	Land Improvements	150,725	0	0	0	2.00
3.00	Buildings and Fixtures	14,924,688	42,911	0	42,911	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	1,004,654	36,291	0	36,291	5.00
6.00	Movable Equipment	3,374,997	49,801	0	49,801	6.00
7.00	Subtotal (sum of lines 1-6)	20,519,064	129,003	0	129,003	7.00
8.00	Reconciling Items	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	20,519,064	129,003	0	129,003	9.00
Description		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,064,000	0			
2.00	Land Improvements	150,725	0			
3.00	Buildings and Fixtures	14,967,599	0			
4.00	Building Improvements	0	0			
5.00	Fixed Equipment	1,040,945	0			
6.00	Movable Equipment	3,424,798	0			
7.00	Subtotal (sum of lines 1-6)	20,648,067	0			
8.00	Reconciling Items	0	0			
9.00	Total (line 7 minus line 8)	20,648,067	0			

ADJUSTMENTS TO EXPENSES

Provider No. : 315426

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

Worksheet A-8

Date/Time Prepared:
5/10/2024 11:45 am

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line No.
			1.00	2.00
1.00 Investment income on restricted funds (chapter 2)	B	-3,084	CAP REL COSTS - BLDGS & FIXTURES	1.00 1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 2.00
3.00 Refunds and rebates of expenses (chapter 8)		0		0.00 3.00
4.00 Rental of provider space by suppliers (chapter 8)		0		0.00 4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 5.00
6.00 Television and radio service (chapter 21)		0		0.00 6.00
7.00 Parking lot (chapter 21)		0		0.00 7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0		8.00
9.00 Home office cost (chapter 21)		0		0.00 9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00 11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-498,031		12.00
13.00 Laundry and linen service	B	-3,099	LAUNDRY & LINEN SERVICE	6.00 13.00
14.00 Revenue - Employee meals		0		0.00 14.00
15.00 Cost of meals - Guests		0		0.00 15.00
16.00 Sale of medical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts		0		0.00 18.00
19.00 Vending machines		0		0.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF	82.00 22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES	1.00 23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT	2.00 24.00
25.00 FACILITY MARKETING	A	-44,379	ADMINISTRATIVE & GENERAL	4.00 25.00
25.01 PATIENT TRANSPORT - NON-AMBULANCE	A	-17	ADMINISTRATIVE & GENERAL	4.00 25.01
25.02 REFERRAL FEES	A	5,880	ADMINISTRATIVE & GENERAL	4.00 25.02
25.03 MARKETING EXPENSE	A	-62,205	ADMINISTRATIVE & GENERAL	4.00 25.03
25.04 MARKETING CORP EXPENSE	A	-9,386	ADMINISTRATIVE & GENERAL	4.00 25.04
25.05 MARKETING - MEALS	A	-22,050	ADMINISTRATIVE & GENERAL	4.00 25.05
25.06 SHOWS & CONFERENCES	A	-2,392	ADMINISTRATIVE & GENERAL	4.00 25.06
25.07 SPONSORSHIPS	A	-417	ADMINISTRATIVE & GENERAL	4.00 25.07
25.08 BAD DEBT EXPENSE	A	-279,563	ADMINISTRATIVE & GENERAL	4.00 25.08
25.09 BAD DEBT EXPENSE - MEDICARE	A	-68,071	ADMINISTRATIVE & GENERAL	4.00 25.09
25.10 BAD DEBT EXPENSE - OTHER	A	28,000	ADMINISTRATIVE & GENERAL	4.00 25.10
25.11 OTHER MEDICAL SERVICES EXPENSE	A	-18,981	SKILLED NURSING FACILITY	30.00 25.11
25.12 OTHER REVENUE	B	-4,908	ADMINISTRATIVE & GENERAL	4.00 25.12
25.13 OTHER INCOME	B	-11,556	ADMINISTRATIVE & GENERAL	4.00 25.13
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-994,259		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. : 315426

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/10/2024 11:45 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1.00
2.00		9.00	NURSING ADMINISTRATION	PHARMACY CONSULTANT	2.00
3.00		10.00	CENTRAL SERVICES & SUPPLY	WOUND CARE EXPENSE	3.00
4.00		11.00	PHARMACY	DRUGS-NON-PRESCRIPTION, NON-LEGEND	4.00
5.00		11.00	PHARMACY	PHARMACY SUPPLIES	5.00
6.00		42.00	INTRAVENOUS THERAPY	IV EXPENSE	6.00
7.00		49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	7.00
8.00		49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	8.00
9.00		49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE A	9.00
9.01		0.00			9.01
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		898,484	1,303,752	-405,268	1.00
2.00		41,364	44,961	-3,597	2.00
3.00		61,750	61,750	0	3.00
4.00		11,561	12,566	-1,005	4.00
5.00		1,076	1,170	-94	5.00
6.00		246,935	268,408	-21,473	6.00
7.00		38,522	41,872	-3,350	7.00
8.00		230,847	250,921	-20,074	8.00
9.00		496,458	539,628	-43,170	9.00
9.01		0	0	0	9.01
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	2,026,997	2,525,028	-498,031	10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/10/2024 11:45 am
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Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	A	CARE ONE	100.00	1.00
2.00	A	CARE ONE	100.00	2.00
3.00	A	CARE ONE	100.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00	HEALTHBRIDGE	100.00	HOME OFFICE	1.00
2.00	PARTNERS PHARMACY	64.87	PHARMACY	2.00
3.00	TOTAL CARE LLC	100.00	WOUND CARE	3.00
4.00		0.00		4.00
5.00		0.00		5.00
6.00		0.00		6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:	0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315426

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

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	3,248,070	3,248,070			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	297,733		297,733		2.00
3.00 00300	EMPLOYEE BENEFITS	1,981,834	0	0	1,981,834	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,277,265	241,471	22,134	127,392	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	879,802	275,554	25,259	31,755	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	130,915	132,680	12,162	13,384	6.00
7.00 00700	HOUSEKEEPING	425,621	0	0	63,805	7.00
8.00 00800	DIETARY	917,763	148,808	13,640	104,389	8.00
9.00 00900	NURSING ADMINISTRATION	1,202,152	121,649	11,151	185,625	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	251,500	0	0	0	10.00
11.00 01100	PHARMACY	12,637	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	39,871	0	0	7,201	12.00
13.00 01300	SOCIAL SERVICE	114,221	8,216	753	20,628	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	180,762	0	0	31,309	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	4,641,463	2,134,898	195,696	781,763	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	102,404	0	0	0	40.00
41.00 04100	LABORATORY	197,459	7,380	676	0	41.00
42.00 04200	INTRAVENOUS THERAPY	246,935	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	1,787,978	50,896	4,665	309,035	44.00
45.00 04500	OCCUPATIONAL THERAPY	1,423,506	44,886	4,114	257,079	45.00
46.00 04600	SPEECH PATHOLOGY	270,311	35,681	3,271	48,469	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,346	1,590	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	765,827	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	49,954	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	21,445,983	3,219,465	295,111	1,981,834	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	4,771	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	10,427	28,605	2,622	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	21,461,181	3,248,070	297,733	1,981,834	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315426

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

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400	2,668,262					4.00
5.00	00500	172,135	1,384,505				5.00
6.00	00600	41,053	67,262	397,456			6.00
7.00	00700	69,490	0	0	558,916		7.00
8.00	00800	168,192	75,439	0	32,009	1,460,240	8.00
9.00	00900	215,895	61,670	0	26,167	0	9.00
10.00	01000	35,708	0	0	0	0	10.00
11.00	01100	1,794	0	0	0	0	11.00
12.00	01200	6,683	0	0	0	0	12.00
13.00	01300	20,420	4,165	0	1,767	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	30,110	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,100,907	1,082,289	397,456	459,224	1,460,240	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	14,540	0	0	0	0	40.00
41.00	04100	29,179	3,741	0	1,587	0	41.00
42.00	04200	35,060	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	305,627	25,802	0	10,948	0	44.00
45.00	04500	245,570	22,755	0	9,655	0	45.00
46.00	04600	50,792	18,088	0	7,675	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	2,689	8,793	0	3,731	0	48.00
49.00	04900	108,734	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	7,093	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		2,661,671	1,370,004	397,456	552,763	1,460,240	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	677	0	0	0	0	90.00
91.00	09100	5,914	14,501	0	6,153	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		2,668,262	1,384,505	397,456	558,916	1,460,240	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315426

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

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	1,824,309					9.00
10.00	01000		287,208				10.00
11.00	01100			14,431			11.00
12.00	01200				53,755		12.00
13.00	01300					170,170	13.00
14.00	01400						14.00
15.00	01500						15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,824,309	287,208	14,431	53,755	170,170	30.00
31.00	03100						31.00
32.00	03200						32.00
33.00	03300						33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000						40.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
44.00	04400						44.00
45.00	04500						45.00
46.00	04600						46.00
47.00	04700						47.00
48.00	04800						48.00
49.00	04900						49.00
50.00	05000						50.00
51.00	05100						51.00
52.00	05200						52.00
52.01	05201						52.01
52.02	05202						52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000						60.00
61.00	06100						61.00
62.00	06200						62.00
63.00	06300						63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000						70.00
71.00	07100						71.00
73.00	07300						73.00
74.00	07400						74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300						83.00
84.00	08400						84.00
84.01	08401						84.01
89.00		1,824,309	287,208	14,431	53,755	170,170	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
93.00	09300						93.00
94.00	09400						94.00
95.00	09500						95.00
98.00							98.00
99.00							99.00
100.00		1,824,309	287,208	14,431	53,755	170,170	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315426

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

Worksheet B
Part I
Date/Time Prepared:
5/10/2024 11:45 am

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	242,181			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	242,181	14,845,990	0	14,845,990
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	116,944	0	116,944
41.00 04100	LABORATORY	0	0	240,022	0	240,022
42.00 04200	INTRAVENOUS THERAPY	0	0	281,995	0	281,995
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	2,494,951	0	2,494,951
45.00 04500	OCCUPATIONAL THERAPY	0	0	2,007,565	0	2,007,565
46.00 04600	SPEECH PATHOLOGY	0	0	434,287	0	434,287
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	34,149	0	34,149
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	874,561	0	874,561
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	57,047	0	57,047
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	242,181	21,387,511	0	21,387,511
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	5,448	0	5,448
91.00 09100	BARBER AND BEAUTY SHOP	0	0	68,222	0	68,222
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	0	242,181	21,461,181	0	21,461,181

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315426

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

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	241,471	22,134	263,605	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	275,554	25,259	300,813	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	132,680	12,162	144,842	6.00
7.00 00700	HOUSEKEEPING	0	0	0	0	7.00
8.00 00800	DIETARY	0	148,808	13,640	162,448	8.00
9.00 00900	NURSING ADMINISTRATION	0	121,649	11,151	132,800	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	8,216	753	8,969	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	2,134,898	195,696	2,330,594	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	7,380	676	8,056	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	50,896	4,665	55,561	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	44,886	4,114	49,000	45.00
46.00 04600	SPEECH PATHOLOGY	0	35,681	3,271	38,952	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,346	1,590	18,936	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	3,219,465	295,111	3,514,576	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	28,605	2,622	31,227	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	3,248,070	297,733	3,545,803	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315426

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

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL	263,605				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	17,006	317,819			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	4,056	15,440	164,338		6.00
7.00	00700	HOUSEKEEPING	6,865	0	0	6,865	7.00
8.00	00800	DIETARY	16,616	17,317	0	393	196,774
9.00	00900	NURSING ADMINISTRATION	21,329	14,157	0	321	0
10.00	01000	CENTRAL SERVICES & SUPPLY	3,528	0	0	0	0
11.00	01100	PHARMACY	177	0	0	0	0
12.00	01200	MEDICAL RECORDS & LIBRARY	660	0	0	0	0
13.00	01300	SOCIAL SERVICE	2,017	956	0	22	0
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0
15.00	01500	ACTIVITIES	2,975	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	108,760	248,443	164,338	5,641	196,774
31.00	03100	NURSING FACILITY	0	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	1,436	0	0	0	0
41.00	04100	LABORATORY	2,883	859	0	19	0
42.00	04200	INTRAVENOUS THERAPY	3,464	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00	04400	PHYSICAL THERAPY	30,194	5,923	0	134	0
45.00	04500	OCCUPATIONAL THERAPY	24,261	5,224	0	119	0
46.00	04600	SPEECH PATHOLOGY	5,018	4,152	0	94	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	266	2,019	0	46	0
49.00	04900	DRUGS CHARGED TO PATIENTS	10,742	0	0	0	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0	0
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0
52.02	05202	MEDICAL SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	0
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00	06200	FQHC	0	0	0	0	0
63.00	06300	DIALYSIS	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00	07100	AMBULANCE	701	0	0	0	0
73.00	07300	CMHC	0	0	0	0	0
74.00	07400	OTHER REIMBURSEMENT	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	0
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	262,954	314,490	164,338	6,789	196,774
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	67	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	584	3,329	0	76	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0
98.00		Cross Foot Adjustments					0
99.00		Negative Cost Centers	0	0	0	0	0
100.00		TOTAL	263,605	317,819	164,338	6,865	196,774

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315426

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

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	168,607					9.00
10.00	01000	0	3,528				10.00
11.00	01100	0	0	177			11.00
12.00	01200	0	0	0	660		12.00
13.00	01300	0	0	0	0	11,964	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	168,607	3,528	177	660	11,964	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		168,607	3,528	177	660	11,964	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		168,607	3,528	177	660	11,964	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315426

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

Worksheet B
Part II
Date/Time Prepared:
5/10/2024 11:45 am

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	2,975			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	2,975	3,242,461	0	3,242,461
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	1,436	0	1,436
41.00 04100	LABORATORY	0	0	11,817	0	11,817
42.00 04200	INTRAVENOUS THERAPY	0	0	3,464	0	3,464
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	91,812	0	91,812
45.00 04500	OCCUPATIONAL THERAPY	0	0	78,604	0	78,604
46.00 04600	SPEECH PATHOLOGY	0	0	48,216	0	48,216
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	21,267	0	21,267
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	10,742	0	10,742
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	701	0	701
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	0	2,975	3,510,520	0	3,510,520
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	67	0	67
91.00 09100	BARBER AND BEAUTY SHOP	0	0	35,216	0	35,216
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	0	2,975	3,545,803	0	3,545,803

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315426

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

Worksheet B-1
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	42,694					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		42,694				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	10,973,686			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,174	3,174	705,387	-2,668,262	18,792,919	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	3,622	3,622	175,830	0	1,212,370	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,744	1,744	74,107	0	289,141	6.00
7.00 00700	HOUSEKEEPING	0	0	353,297	0	489,426	7.00
8.00 00800	DIETARY	1,956	1,956	578,017	0	1,184,600	8.00
9.00 00900	NURSING ADMINISTRATION	1,599	1,599	1,027,832	0	1,520,577	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	251,500	10.00
11.00 01100	PHARMACY	0	0	0	0	12,637	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	39,871	0	47,072	12.00
13.00 01300	SOCIAL SERVICE	108	108	114,221	0	143,818	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	0	0	173,361	0	212,071	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	28,062	28,062	4,328,735	0	7,753,820	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	102,404	40.00
41.00 04100	LABORATORY	97	97	0	0	205,515	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	246,935	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	669	669	1,711,168	0	2,152,574	44.00
45.00 04500	OCCUPATIONAL THERAPY	590	590	1,423,479	0	1,729,585	45.00
46.00 04600	SPEECH PATHOLOGY	469	469	268,381	0	357,732	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	228	228	0	0	18,936	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	765,827	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00 05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01 05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02 05202	MEDICAL SERVICES	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	DIALYSIS	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	49,954	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSEMENT	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW - SNF						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01 08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	42,318	42,318	10,973,686	-2,668,262	18,746,494	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	4,771	90.00
91.00 09100	BARBER AND BEAUTY SHOP	376	376	0	0	41,654	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	3,248,070	297,733	1,981,834		2,668,262	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	76.077903	6.973650	0.180599		0.141982	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		263,605	104.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315426

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

Worksheet B-1

Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
105.00 Unit cost multiplier (Wkst. B, Part 11)			0.000000	4A	0.014027	105.00	

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315426

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

Worksheet B-1
Date/Time Prepared:
5/10/2024 11:45 am

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	35,898					6.00
7.00	00700	1,744	32,439				7.00
8.00	00800	0	0	34,154			8.00
9.00	00900	1,956	0	1,956	97,317		9.00
10.00	01000	1,599	0	1,599	0	32,439	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	108	0	108	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28,062	32,439	28,062	97,317	32,439	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	97	0	97	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	669	0	669	0	0	44.00
45.00	04500	590	0	590	0	0	45.00
46.00	04600	469	0	469	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	228	0	228	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
52.01	05201	0	0	0	0	0	52.01
52.02	05202	0	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
84.01	08401	0	0	0	0	0	84.01
89.00		35,522	32,439	33,778	97,317	32,439	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	376	0	376	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00		1,384,505	397,456	558,916	1,460,240	1,824,309	102.00
103.00		38.567748	12.252412	16.364584	15.004984	56.238139	103.00
104.00		317,819	164,338	6,865	196,774	168,607	104.00
105.00		8.853390	5.066062	0.201001	2.021990	5.197663	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315426

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

Worksheet B-1

Date/Time Prepared:
5/10/2024 11:45 am

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	32,439					10.00	
11.00	01100	0	32,439				11.00	
12.00	01200	0	0	32,439			12.00	
13.00	01300	0	0	0	32,439		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	32,439	32,439	32,439	32,439	0	30.00	
31.00	03100	0	0	0	0	0	31.00	
32.00	03200	0	0	0	0	0	32.00	
33.00	03300	0	0	0	0	0	33.00	
ANCILLARY SERVICE COST CENTERS								
40.00	04000	0	0	0	0	0	40.00	
41.00	04100	0	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	0	0	0	0	0	43.00	
44.00	04400	0	0	0	0	0	44.00	
45.00	04500	0	0	0	0	0	45.00	
46.00	04600	0	0	0	0	0	46.00	
47.00	04700	0	0	0	0	0	47.00	
48.00	04800	0	0	0	0	0	48.00	
49.00	04900	0	0	0	0	0	49.00	
50.00	05000	0	0	0	0	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
52.00	05200	0	0	0	0	0	52.00	
52.01	05201	0	0	0	0	0	52.01	
52.02	05202	0	0	0	0	0	52.02	
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
63.00	06300	0	0	0	0	0	63.00	
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
73.00	07300	0	0	0	0	0	73.00	
74.00	07400	0	0	0	0	0	74.00	
SPECIAL PURPOSE COST CENTERS								
80.00	08000						80.00	
81.00	08100						81.00	
82.00	08200						82.00	
83.00	08300	0	0	0	0	0	83.00	
84.00	08400	0	0	0	0	0	84.00	
84.01	08401	0	0	0	0	0	84.01	
89.00	SUBTOTALS (sum of lines 1-84)						0	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	09300	0	0	0	0	0	93.00	
94.00	09400	0	0	0	0	0	94.00	
95.00	09500	0	0	0	0	0	95.00	
98.00	Cross Foot Adjustments						98.00	
99.00	Negative Cost Centers						99.00	
102.00	Cost to be allocated (per Wkst. B, Part I)	287,208	14,431	53,755	170,170	0	102.00	
103.00	Unit cost multiplier (Wkst. B, Part I)	8.853787	0.444866	1.657110	5.245846	0.000000	103.00	
104.00	Cost to be allocated (per Wkst. B, Part II)	3,528	177	660	11,964	0	104.00	
105.00	Unit cost multiplier (Wkst. B, Part II)	0.108758	0.005456	0.020346	0.368815	0.000000	105.00	

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315426

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

Worksheet B-1
Date/Time Prepared:
5/10/2024 11:45 am

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	32,439	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	32,439	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF/IID	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	40.00
41.00	04100	LABORATORY	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100	SUPPORT SURFACES	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	52.01
52.02	05202	MEDICAL SERVICES	0	52.02
OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FQHC	0	62.00
63.00	06300	DIALYSIS	0	63.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
73.00	07300	CMHC	0	73.00
74.00	07400	OTHER REIMBURSEMENT	0	74.00
SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	84.00
84.01	08401	OTHER SPECIAL PURPOSE COST II	0	84.01
89.00		SUBTOTALS (sum of lines 1-84)	32,439	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	95.00
98.00		Cross Foot Adjustments		98.00
99.00		Negative Cost Centers		99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	242,181	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	7.465736	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	2,975	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.091711	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS			Provider No. : 315426		Period: From 01/01/2023 To 12/31/2023		Worksheet C Date/Time Prepared: 5/10/2024 11:45 am	
Cost Center Description			Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)			
			1.00	2.00	3.00			
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	116,944	256,010	0.456795			40.00
41.00	04100	LABORATORY	240,022	493,647	0.486222			41.00
42.00	04200	INTRAVENOUS THERAPY	281,995	671,020	0.420248			42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000			43.00
44.00	04400	PHYSICAL THERAPY	2,494,951	7,234,075	0.344889			44.00
45.00	04500	OCCUPATIONAL THERAPY	2,007,565	6,844,020	0.293331			45.00
46.00	04600	SPEECH PATHOLOGY	434,287	1,157,148	0.375308			46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000			47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,149	0	0.000000			48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	874,561	2,081,053	0.420249			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
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000			52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0.000000			52.01
52.02	05202	MEDICAL SERVICES	0	0	0.000000			52.02
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0.000000			60.00
61.00	06100	RURAL HEALTH CLINIC						61.00
62.00	06200	FOHC						62.00
63.00	06300	DIALYSIS	0	0	0.000000			63.00
71.00	07100	AMBULANCE	57,047	124,885	0.456796			71.00
100.00		Total	6,541,521	18,861,858				100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/10/2024 11:45 am
		Title XVIII (1)	Skilled Nursing Facility	PPS

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost		
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
			1.00	2.00	3.00	4.00	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0.456795	48,270	0	22,049	0 40.00
41.00	04100	LABORATORY	0.486222	144,305	0	70,164	0 41.00
42.00	04200	INTRAVENOUS THERAPY	0.420248	83,870	0	35,246	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0 43.00
44.00	04400	PHYSICAL THERAPY	0.344889	2,999,545	0	1,034,510	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	0.293331	2,891,933	0	848,294	0 45.00
46.00	04600	SPEECH PATHOLOGY	0.375308	294,696	0	110,602	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	0.420249	280,449	0	117,858	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
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0.000000	0	0	0	0 52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0.000000	0	0	0	0 52.01
52.02	05202	MEDICAL SERVICES	0.000000	0	0	0	0 52.02
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0.000000	0	0	0	0 60.00
61.00	06100	RURAL HEALTH CLINIC					61.00
62.00	06200	FOHC					62.00
63.00	06300	DIALYSIS	0.000000	0	0	0	0 63.00
71.00	07100	AMBULANCE (2)	0.456796		0		0 71.00
100.00		Total (Sum of lines 40 - 71)		6,743,068	0	2,238,723	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. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/10/2024 11:45 am
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description			1.00	
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PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	0.420249	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	1,313	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)	552	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	116,944	0	0.000000	22,049	0	40.00
41.00	04100	LABORATORY	240,022	0	0.000000	70,164	0	41.00
42.00	04200	INTRAVENOUS THERAPY	281,995	0	0.000000	35,246	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	2,494,951	0	0.000000	1,034,510	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	2,007,565	0	0.000000	848,294	0	45.00
46.00	04600	SPEECH PATHOLOGY	434,287	0	0.000000	110,602	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,149	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	874,561	0	0.000000	117,858	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
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	0	0	52.00
52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0.000000	0	0	52.01
52.02	05202	MEDICAL SERVICES	0	0	0.000000	0	0	52.02
100.00		Total (Sum of lines 40 - 52)	6,484,474	0		2,238,723	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/10/2024 11:45 am
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		32,439	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		18,793	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		14,845,990	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		18,512,546	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.801942	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)		14,845,990	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		457.66	16.00
17.00	Program routine service cost (Line 3 times line 16)		8,600,804	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)		8,600,804	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)		3,242,461	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		99.96	21.00
22.00	Program capital related cost (Line 3 times line 21)		1,878,548	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		6,722,256	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)		6,722,256	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

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

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		32,439	1.00
2.00	Program inpatient days (see instructions)		18,793	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)		0.579334	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:45 am
		Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		16,476,577	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)		16,476,577	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		2,128,024	5.00
6.00	Allowable bad debts (From your records)		183,976	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		119,584	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)		14,468,137	11.00
12.00	Interim payments (See instructions)		14,249,457	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)		2,392	14.75
14.99	Sequestration amount (see instructions)		286,971	14.99
15.00	Balance due provider/program (see Instructions)		-70,683	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		552	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		552	19.00
20.00	Medicare Part B ancillary charges (See instructions)		1,313	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		552	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)		552	25.00
26.00	Interim payments (See instructions)		1,287	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)		11	28.99
29.00	Balance due provider/program (see instructions)		-746	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/10/2024 11:45 am	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		14,061,582		1,287
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		161,411		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/09/2023	26,464		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		26,464		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		14,249,457		1,287
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	PROGRAM TO PROVIDER		0		0
6.02	PROVIDER TO PROGRAM		70,683		746
7.00	Total Medicare program liability (see instructions)		14,178,774		541
		Contractor Name		Contractor Number	
		1.00		2.00	
8.00	Name of Contractor				

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

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

Provider No. : 315426

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

Worksheet G

Date/Time Prepared:
5/10/2024 11:45 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	82,079	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	3,268,310	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	-526,314	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	27,716	0	0	0	8.00
9.00	Other current assets	10,636	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2,862,427	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,064,000	0	0	0	12.00
13.00	Land improvements	150,725	0	0	0	13.00
14.00	Less: Accumulated depreciation	-23,735	0	0	0	14.00
15.00	Buildings	14,967,599	0	0	0	15.00
16.00	Less Accumulated depreciation	-11,161,848	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	1,040,945	0	0	0	19.00
20.00	Less: Accumulated depreciation	-1,112,846	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	3,424,798	0	0	0	23.00
24.00	Less: Accumulated depreciation	-2,699,661	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	304,962	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	5,954,939	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	373,469	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	373,469	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	9,190,835	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,987,628	0	0	0	35.00
36.00	Salaries, wages, and fees payable	227,958	0	0	0	36.00
37.00	Payroll taxes payable	-1,340	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	10,636	0	0	0	41.00
42.00	Other current liabilities	1,962,498	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4,187,380	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	50,013,018	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	-66,078,965	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)	-16,065,947	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-11,878,567	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	21,069,402	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)	21,069,402	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	9,190,835	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315426

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

Worksheet G-1

Date/Time Prepared:
5/10/2024 11:45 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		17,942,630		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		3,654,749			2.00
3.00	Total (sum of line 1 and line 2)		21,597,379		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		21,597,379		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00	DRAW	527,977		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		527,977		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		21,069,402		0	19.00
		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)					4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 5 - 9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)					12.00
13.00	DRAW		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. : 315426

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/10/2024 11:45 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	18,512,546		18,512,546	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)	18,512,546		18,512,546	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	18,861,858	0	18,861,858	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)	37,374,404	0	37,374,404	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			22,455,440	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			22,455,440	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No. : 315426	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/10/2024 11:45 am
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		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	37,374,404	1.00
2.00	Less: contractual allowances and discounts on patients accounts	11,301,946	2.00
3.00	Net patient revenues (Line 1 minus line 2)	26,072,458	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	22,455,440	4.00
5.00	Net income from service to patients (Line 3 minus 4)	3,617,018	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,084	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	3,099	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	BARBER & BEAUTY	14,703	24.00
24.01	OTHER REVENUE	4,908	24.01
24.02	NJ PROVIDER TAX INCOME	381	24.02
24.03	OTHER INCOME	11,556	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	37,731	25.00
26.00	Total (Line 5 plus line 25)	3,654,749	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	3,654,749	31.00