12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315002 Worksheet S Parts I, II & III Peri od: From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/10/2024 11:59 am PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 5/10/2024 Time: 11:59 am use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[0]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code

for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

5. Date Received:

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 SOMERSET VALLEY REHAB AND NURSING CT (315002) 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Dav	rid Baruch	l t	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	Davi d Baruch			2
3	Signatory Title	DBARUCH@CARE-ONE. COM			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-53, 119	0	0	1. 00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-53, 119	0	0	100.00

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

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

Health Financial Systems SOMERSET VALLEY REHAB AND NURSING CT In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315002 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:59 am 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 1621 ROUTE 22 WEST PO Box: 1.00 2.00 City: BOUND BROOK State: NJ Zi p Code: 08805 2.00 3.00 County: SOMERSET CBSA Code: 35154 Urban/Rural: U 3.00 CBSA Code: 3. 01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF SOMERSET VALLEY REHAB 315002 12/29/1996 N Р Ν 4.00 AND NURSING CT 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 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) 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 Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related Υ 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 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 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits d 22.00 22.00 Sum of line 20 through 22 23 00 23.00 Q 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26,00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) 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 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 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 Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry mal practice insurance? (Y/N) Υ 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses:

13 072

0

41.00

Heal th	Health Financial Systems SOMERSET VALLEY REHAB AND NURSING CT In Lieu					2540-10
					Worksheet S-2	
COMPLE	EX INDENTIFICATION DATA			From 01/01/2023		
				To 12/31/2023		
					5/10/2024 11:	<u>59 am</u>
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative a	nd General cost	N	42.00
	center? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listing cost	centers and		
	amounts.		G			
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Ch	apter 10?		Υ	43.00
44.00	If line 43 is yes, enter the home offi	ce chain number and enter	the name and address	of the home	HB0206	44. 00
	office on lines 45, 46 and 47.					
	1.00	2.00		3.00		
	If this facility is part of a chain or	ganization, enter the nam	e and address of the	home office on the	lines	
	bel ow.					
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contrac	ctor's Number: 1200)1	45. 00
46. 00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46.00
47. 00	City: FORT LEE	State: NJ	Zi p Coo	de: 0702	24	47. 00

leal th	Financial Systems SOMER	RSET VALLEY REHAB A	ND NURSING	G CT	In Li€	eu of Form CMS	-2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der	No.: 315002	Peri od: From 01/01/2023 To 12/31/2023		epared:
					Y/N	Date	. 37 dili
	General Instruction: For all column 1 respons		1 \/ -	V !! N!!!	1.00	2.00	
	responses the format will be (mm/dd/yyyy)	ses enter in column	1 I, "Y" TC	or yes or "N"	TOT NO. FOR ALL	tne date	
	Completed by All Skilled Nursing Facilites						
1. 00	Provider Organization and Operation Has the provider changed ownership immediately reporting period? If column 1 is "Y", enter instructions)	ly prior to the beg the date of the cha	ginning of ange in col	the cost umn 2. (see	N		1.00
	instructions)			Y/N	Date	V/I	
				1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and	in column	N			2.00
3. 00	Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or relationships? (see instructions)	., chain home offic d to the provider o I, or members of th	ces, drug or its ne board	Y			3.00
	refute onem per (ese mistraetrene)			Y/N	Туре	Date	
				1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements preparaccountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complete	" for Audited, "C"	for	Y	A		4.00
5. 00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If a reconciliation.	revenues di fferent	from	N			5. 00
				1	Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
o. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	, ,		provi der the	N	N	6.00
7. 00 3. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so	ng the cost reporti		for Nursing	N N		7. 00 8. 00
						1. 00	
	Bad Debts					1.00	
9. 00 10. 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				st reporting	Y N	9. 00 10. 00
	If line 9 is "Y", are patient deductibles and Bed Complement					N N	11.00
12. 00	Have total beds available changed from prior	cost reporting per	iod? If "\		uc <u>tions.</u> art A	N Part B	12. 00
		Description	on	Y/N	Date	Y/N	
		0		1.00	2. 00	3.00	
3. 00	PS&R Data 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			Y	03/19/2024	Y	13. 00
4. 00	prepare this cost report in cols. 2 and 4. (see Instructions.) 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"			N		N	14. 00
15. 00	enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 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			N		N	15. 00

Ν

Ν

16.00

17.00

18.00

Ν

Ν

16.00

have been billed but are not included on the PS&R used to file this cost report? If "Y",

adjustments made to PS&R data for Other?
Describe the other adjustments:
Was the cost report prepared only using the provider's records? If "Y" see Instructions.

see Instructions. 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.

17.00 If line 13 or 14 is "Y", then were

Heal th	Financial Systems SOMERSE	T VALLEY REHA	AB AND NURSIN	G CT	In Lieu of Form CMS-2540-		
SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILITY	HEALTH CARE	Provi der	No.: 315002	Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			<u>'</u>				
			1	. 00	2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/p		CHARLES		REED		19. 00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost rep	ort E	EXECUCARE ASS	OCI ATES			20. 00
	preparer.						
21. 00	Enter the telephone number and email address of		(609) 738-3200		CRWASSC@NETSCAI	PE. NET	21. 00
	report preparer in columns 1 and 2, respectivel	y.					

Health Financial Systems

SOMERSET VALLEY REHAB AND NURSING CT

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

COMPLEX REIMBURSEMENT QUESTIONNAIRE

Part B

Date
4.00

PS&R Data

SOMERSET VALLEY REHAB AND NURSING CT

In Lieu of Form CMS-2540-10

Worksheet S-2

Part II

Date/Time Prepared:
5/10/2024 11: 59 am

		Part B		37 107 2024 111.	O / uiii
			-		
		Date	-		
	DCAR R I	4. 00			_
	PS&R Data		1		
13. 00	Was the cost report prepared using the PS&R	03/19/2024			13. 00
	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.)				
14. 00	Was the cost report prepared using the PS&R				14. 00
	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.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
	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.				
16. 00	If line 13 or 14 is "Y", then were				16. 00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
47.00	information? If yes, see instructions.				17.00
17.00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
40.00	Describe the other adjustments:				10.00
18. 00					18. 00
	provider's records? If "Y" see Instructions.				
			3.00		
	Cost Report Preparer Contact Information		3.00		
19. 00	Enter the first name, last name and the title	/nosi ti on	VI CE-PRESI DENT		19. 00
19.00	held by the cost report preparer in columns 1		VI CE-FRESI DENI		19.00
	respectively.	i, z, aiiu s,			
20. 00	Enter the employer/company name of the cost r	conort			20.00
20.00	preparer.	epoi t			20.00
21. 00	Enter the telephone number and email address	of the cost			21. 00
21.00	report preparer in columns 1 and 2, respective				21.00
	property property in continues raina 2, respective	, or y .	1	1	1

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

Provi der No.: 315002

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/10/2024 11:59 am Inpatient Days/Visits Title XVIII Number of Beds Bed Days Title V Title XIX Component Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 23, 360 11, 470 0 1.00 64 C NURSING FACILITY 0 2.00 0 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 Ω 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 0 7.00 0 8.00 Total (Sum of lines 1-7) 64 23, 360 11, 470 8.00 Inpatient Days/Visits Di scharges Title XIX 0ther Title XVIII Component Total Title V 6.00 7.00 8.00 9.00 10.00 1.00 SKILLED NURSING FACILITY 7, 243 18, 713 0 440 0 1. 00 0 2.00 NURSING FACILITY 0 0 2.00 0 ICE/LID 3 00 3 00 C 0 4.00 HOME HEALTH AGENCY COST 0 4.00 5.00 Other Long Term Care 0 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 0 7.00 8.00 Total (Sum of lines 1-7) 7, 243 18, 713 440 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 0.00 1.00 395 835 26.07 NURSING FACILITY 2.00 0 0.00 0.00 2.00 3.00 ICF/IID 0 C 0.00 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 0.00 0.00 7.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 395 835 0.00 26.07 0.00 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16, 00 17.00 18.00 19 00 20.00 1.00 SKILLED NURSING FACILITY 22. 41 473 355 1. 00 NURSING FACILITY 0.00 0 2.00 2.00 0 ICF/IID 0.00 0 3.00 0 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 0.00 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 00 C Ω 7 00 Total (Sum of lines 1-7) 22. 41 473 355 8.00 8.00 Admi ssi ons Full Time Equivalent Total Component Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 828 0.00 90.34 1.00 NURSING FACILITY 0.00 2.00 2.00 0.00 0 0.00 3.00 ICF/IID 0 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0 0.00 0.00 5.00 6.00 SNF-Based CMHC 0.00 6.00 0.00 7.00 HOSPI CE Λ 0.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 828 90.34 0.00 8.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315002

					0 12/31/2023	5/10/2024 11:	
	·	Amount	Reclass. of	Adjusted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
		·	Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES				1		
1.00	Total salaries (See Instructions)	6, 015, 010	0	6, 015, 010			1. 00
2.00	Physician salaries-Part A	0	0	0	0.00		
3.00	Physician salaries-Part B	0	0	0	0.00		
4.00	Home office personnel	0	0	0	0.00		
5.00	Sum of lines 2 through 4	0	0	0	0.00		
6.00	Revised wages (line 1 minus line 5)	6, 015, 010	0	6, 015, 010	187, 912. 00	32. 01	6. 00
7.00	Other Long Term Care	0	0	C	0.00		7. 00
8.00	HOME HEALTH AGENCY COST	0	0	C	0.00	0.00	8. 00
9.00	CMHC	0	0	C	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	C	0.00	0.00	10.00
11.00	Other excluded areas	0	0	C	0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	C	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	6, 015, 010	0	6, 015, 010	187, 912. 00	32. 01	13. 00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	31, 710	0	31, 710			14.00
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		15. 00
16. 00	Home office salaries & wage related costs	0	0	C	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	1, 618, 642	0	1, 618, 642			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	C			18. 00
19.00	Wage related costs (excluded units)	0	0	C			19. 00
20.00	Physician Part A - WRC	0	0	C			20. 00
21.00	Physician Part B - WRC	0	0	C			21. 00
22.00	Total Adjusted Wage Related cost (see	1, 618, 642	0	1, 618, 642			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315002

						5/10/2024 11:	59 am_
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col . 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1.00
2.00	Administrative & General	468, 495	0	468, 495	11, 814. 00	39. 66	2.00
3.00	Plant Operation, Maintenance & Repairs	85, 107	0	85, 107	3, 489. 00	24. 39	3. 00
4.00	Laundry & Linen Service	74, 127	0	74, 127	3, 979. 00	18. 63	4.00
5.00	Housekeepi ng	227, 440	0	227, 440	12, 848. 00	17. 70	5. 00
6.00	Di etary	370, 768	0	370, 768	23, 660. 00	15. 67	6. 00
7.00	Nursing Administration	533, 403	0	533, 403	11, 575. 00	46. 08	7. 00
8.00	Central Services and Supply	40, 318	o	40, 318	2, 034. 00	19. 82	8. 00
9.00	Pharmacy	0	0	ol c	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	1, 943	0	1, 943	100.00	19. 43	10.00
11.00	Soci al Servi ce	105, 534	0	105, 534	2, 963. 00	35. 62	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	121, 936	0	121, 936	6, 628. 00	18. 40	13.00
14. 00	Total (sum lines 1 thru 13)	2, 029, 071	0	2, 029, 071	79, 090. 00	25. 66	14. 00

Provi der No.: 315002

PART IV - WAGE RELATED COSTS 1.00		To 12/31/2023		
PART IV - WAGE RELATED COSTS			1'	37 aiii
PART I V - WAGE RELATED COSTS Part A - Core List RETIREMENT COST				
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 33,892 1.00 2.00 7				
Part A - Core List RETIREMENT COST		PART IV - WAGE RELATED COSTS	1.00	
RETIREMENT COST				
1.00				
2.00	1 00		33 892	1 00
3.00 Qualified and Non-Qualified Pension Plan Cost 0 3.00 Prior Year Pension Service Cost 0 4.00 Prior Year Pension Service Cost 0 5.00 4.00 4.00 Prior Year Pension Service Cost 0 5.00 4.00			1	
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 Composition Compo	00		Ü	
Column C	5. 00		0	5.00
To Employee Managed Care Program Administration Fees 1,006,390 1,046,3				
HEALTH AND INSURANCE COST			· -	
Real th Insurance (Purchased or Self Funded) 1,046,390 9.00 Prescription Drug Plan 0 9.00 0.00 0.00 0.00 0.001 0.00 0.001 0.00	7.00		9	7.00
9.00 Prescription Drug Plan	8 00		1 046 390	8 00
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 1,309 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 43,439 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 17.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 17.00 FICA-Employers Portion Only 420,933 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 70,285 20.00 OTHER 2.394 23.00 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 2,394 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,618,642 24.00 Part B - Other than Core Related Cost				
11.00			0	
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 43, 439 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 420, 933 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 0 19.00 20.00 State or Federal Unemployment Taxes 70, 285 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 2, 394 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost				
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 43, 439 15.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion)				
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00				
15. 00 Workers' Compensation Insurance 43, 439 15. 00			- 1	
Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only Unemployment Insurance 50.00 State or Federal Unemployment Taxes TO, 285 To Day Care Cost and Allowances Tuition Reimbursement 20.00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost			43 439	
Non cumulative portion TAXES TAXES TO			1	
TAXES 17.00 FI CA-Employers Portion Only				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 70,285 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 2,394 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,618,642 24.00 Amount Reported Amount Reported 1.00 1.00				
19.00 Unemployment Insurance 19.00 20.00 State or Federal Unemployment Taxes 70,285 20.00 20.0	17. 00	FICA-Employers Portion Only	420, 933	17. 00
19.00 Unemployment Insurance 19.00 20.00 State or Federal Unemployment Taxes 70,285 20.00 20.0			1	
20.00 State or Federal Unemployment Taxes 70, 285 20.00 OTHER			0	19.00
OTHER 21.00 Executive Deferred Compensation 0 21.00			70. 285	20.00
22.00 Day Care Cost and Allowances 0 22.00				
22.00 Day Care Cost and Allowances 0 22.00	21. 00	Executive Deferred Compensation	0	21. 00
24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,618,642 24.00 Amount Reported 1.00			0	22. 00
Amount Reported 1.00 Part B - Other than Core Related Cost			2, 394	
Amount Reported 1.00 Part B - Other than Core Related Cost	24. 00	Total Wage Related cost (Sum of lines 1 - 23)	1, 618, 642	24. 00
Part B - Other than Core Related Cost				
Part B - Other than Core Related Cost				
25. 00 OTHER WAGE RELATED COST 0 25. 00		Part B - Other than Core Related Cost		
	25.00	OTHER WAGE RELATED COST	0	25. 00

Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES

Provi der No.: 315002

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part V | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 1

				'	0 12/31/2023	5/10/2024 11:	
	Occupational Category	Amount	Fri nge	Adj usted	Paid Hours	Average Hourly	
		Reported	Benefits	Salaries (col.		Wage (col. 3 ÷	
				1 + col . 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3.00	4. 00	5. 00	
	Di rect Sal ari es						
1. 00	Nursing Occupations Registered Nurses (RNs)	890, 580	243, 587	1, 134, 167	18, 021. 00	62. 94	1. 00
2.00	Licensed Practical Nurses (LPNs)	794, 890	243, 367				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 012, 748	277, 002				3. 00
3.00	Assistants/Aides	1,012,746	277,002	1, 209, 750	40, 170.00	32.11	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2, 698, 218	738, 003	3, 436, 221	79, 508. 00	43. 22	4. 00
5.00	Physical Therapists	580, 355	158, 736	739, 091	14, 385. 00	51. 38	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	468, 553	128, 156	596, 709	12, 840. 00	46. 47	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	125, 812	34, 411	160, 223	2, 086. 00	76. 81	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13. 00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	0		0	0. 00		
15. 00	Licensed Practical Nurses (LPNs)	0		0	0.00		15. 00
16. 00	Certified Nursing Assistant/Nursing	0		0	0.00	0.00	16. 00
17. 00	Assistants/Aides Total Nursing (sum of lines 14 through 16)				0.00	0.00	17. 00
18. 00	Physical Therapists				0.00		18. 00
19. 00	Physical Therapy Assistants				0.00		19. 00
20. 00	Physical Therapy Aides				0.00		
20.00		0		0	0.00		20.00
21.00	Occupational Therapists Occupational Therapy Assistants			0	0.00		
23. 00	Occupational Therapy Aides				0.00		
24. 00	Speech Therapists	1, 750		1, 750			
25. 00	Respiratory Therapists	29, 960		29, 960			24. 00 25. 00
26. 00	Other Medical Staff	29, 960		29, 960	0.00		26. 00
20.00	Tottlei Medical Stail	١		1	0.00	0.00	20.00

Peri od:

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/10/2024 11:59 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 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 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 30.00 HD1 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 44.00 CE1 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 52 00 CA1 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 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 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 75. 00 PA₂

Health Financial Systems	G CT	CT In Lieu of Form CMS-2540-				
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:	
				5/10/2024 11:	59 am	
			Group	Days		
7, 00			1. 00	2. 00	77.00	
76. 00			PA1		76. 00	
99. 00			AAA		99. 00	
100. 00 TOTAL					100. 00	
		Expenses	Percentage	Y/N		
		1.00	2. 00	3. 00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)						
101. 00 Staffi ng					101. 00	
102.00 Recrui tment					102. 00	
103.00 Retention of employees					103. 00	
104. 00 Trai ni ng					104. 00	
105. 00 OTHER (SPECIFY)					105. 00	
106.00 Total SNF revenue (Worksheet G-2, Part	I, line 1, column 3)	1		l	106. 00	

Health Financial Systems In Lieu of Form CMS-2540-10 RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315002 Peri od: Worksheet A From 01/01/2023 12/31/2023 Date/Time Prepared: 5/10/2024 11:59 am Cost Center Description Sal ari es 0ther Total (col. 1 Reclassi fi cati Reclassi fied + col . 2) Trial Balance ons (col . 3 +-col . 4) ncrease/Decre ase (Fr Wkst A-6) 1.00 2.00 3.00 4.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 2, 526, 504 2, 526, 504 2, 526, 504 1.00 0 11, 503 2.00 11.503 11.503 2.00 3.00 00300 EMPLOYEE BENEFITS 1, 645, 196 1, 645, 196 1, 645, 196 3.00 00400 ADMINISTRATIVE & GENERAL 468, 495 1, 781, 791 1, 781, 791 4.00 1, 313, 296 0 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 85, 107 329, 416 5.00 414, 523 414, 523 5.00 00600 LAUNDRY & LINEN SERVICE 29, 708 6.00 74, 127 103, 835 103, 835 6.00 0 7.00 00700 HOUSEKEEPI NG 227, 440 22, 873 250, 313 250, 313 7.00 8.00 00800 DI ETARY 370, 768 167, 855 538, 623 0 0 0 538, 623 8.00 00900 NURSING ADMINISTRATION 113, 655 9 00 533 403 647 058 647, 058 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 40, 318 204, 093 244, 411 244, 411 10.00 11.00 01100 PHARMACY 10, 255 10, 255 10, 255 11.00 0 12.00 01200 MEDICAL RECORDS & LIBRARY 1,943 C 1, 943 1, 943 12.00 01300 SOCIAL SERVICE 105, 534 13 00 105, 534 105, 534 13 00 Ω 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION \cap 0 Λ 14.00 01500 ACTI VI TES 15.00 121, 936 963 122, 899 122, 899 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 2, 698, 218 52, 245 2, 750, 463 0 2, 750, 463 30.00 03100 NURSING FACILITY 0 31.00 31.00 0 32.00 03200 | CF/IID 0 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 O 33 00 33 00 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 40, 989 40, 989 40.00 0 40.989 0 41.00 04100 LABORATORY 0 75, 327 75, 327 75, 327 41.00 04200 I NTRAVENOUS THERAPY 0 42 00 42 00 176, 867 176, 867 176, 867 0 43.00 04300 OXYGEN (INHALATION) THERAPY 43.00 04400 PHYSI CAL THERAPY 693, 356 707, 788 707, 788 44.00 14, 432 0 44.00 04500 OCCUPATIONAL THERAPY 468, 553 45.00 468, 553 468, 553 45.00 04600 SPEECH PATHOLOGY 125, 812 46.00 1, 750 127, 562 127, 562 46.00 0 04700 ELECTROCARDI OLOGY 47.00 47.00 C 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 0 48 00 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 611, 495 611, 495 49.00 611, 495 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 C Ω 50.00 05100 SUPPORT SURFACES 0 0 0 51.00 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 0 52.00 Ω 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 52.01 0 0 52.01 C 0 52.02 05202 MEDICAL SERVICES O 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 61.00 Λ 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 o 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 92, 190 92, 190 0 92, 190 71.00 0 o 73.00 07300 CMHC 73.00 C 0 07400 OTHER REIMBURSEMENT 74.00 0 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 0 0 80.00 0 08100 INTEREST EXPENSE 81.00 0 81.00 0 82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 82.00 83.00 08300 H0SPI CE 0 0 0 0 0 83.00 0 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 0 84 01 08401 OTHER SPECIAL PURPOSE COST II O 84 01 0 SUBTOTALS (sum of lines 1-84) 6,015,010 89.00 7, 440, 612 13, 455, 622 13, 455, 622 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 5, 654 90.00 0 5, 654 5,654 09100 BARBER AND BEAUTY SHOP 0 91 00 0 91 00 C 0 0 92.00 0 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 0 92.00 09300 NONPALD WORKERS 0 0 0 93.00 93.00 0 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 09500 OTHER NONREI MBURSABLE COST 95 00 0 95 00 0 100.00 TOTAL 6, 015, 010 7, 446, 266 13, 461, 276 13, 461, 276 100. 00

Heal th FinancialSystemsSOMERSET VALLEY REHAB AND NURSING CTRECLASSIFICATIONAND ADJUSTMENT OF TRIAL BALANCE OF EXPENSESProvider No.: Provi der No.: 315002

			To 12/31/2023 Date/Time Pre 5/10/2024 11:	
Cost Center Description	Adjustments to	Net Expenses	67.107.2021	J / G
		For Allocation		
	Wkst A-8)	(col. 5 +-		
	6.00	col . 6) 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00	<u> </u>	
1. 00 O0100 CAP REL COSTS - BLDGS & FIXTURES	-1, 484, 012	1, 042, 492		1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	11, 503		2. 00
3.00 00300 EMPLOYEE BENEFITS	0	1, 645, 196		3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	-406, 067	1, 375, 724	·	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	0	414, 523	·	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	0	103, 835	l .	6.00
7. 00 00700 HOUSEKEEPI NG 8. 00 00800 DI ETARY	0	250, 313 538, 623		7. 00 8. 00
9. 00 00900 NURSI NG ADMINI STRATI ON	-2, 084	644, 974	•	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	0	244, 411		10.00
11. 00 01100 PHARMACY	-820			11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	1, 943		12. 00
13. 00 01300 SOCI AL SERVI CE	0	105, 534		13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0		I .	14. 00
15. 00 01500 ACTIVITES	0	122, 899		15. 00
30. 00 03000 SKILLED NURSING FACILITY	-5, 695	2, 744, 768		30.00
31. 00 03100 NURSI NG FACILITY	-5, 695	2, 744, 766		31.00
32. 00 03200 CF/IID	0			32. 00
33.00 03300 OTHER LONG TERM CARE	0	1		33. 00
ANCILLARY SERVICE COST CENTERS				
40. 00 04000 RADI OLOGY	0	40, 989		40. 00
41. 00 04100 LABORATORY	0	,		41. 00
42. 00 04200 I NTRAVENOUS THERAPY	-14, 149	1	l .	42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY	0	0	l .	43.00
44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 OCCUPATI ONAL THERAPY	0	707, 788 468, 553		44. 00 45. 00
46. 00 04600 SPEECH PATHOLOGY	0	127, 562		46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0		47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	-48, 919	562, 576		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 52. 02 05202 MEDICAL SERVICES	0 0	0	l .	52. 01 52. 02
OUTPATIENT SERVICE COST CENTERS	0	0	1	32.02
60. 00 06000 CLINIC	0	0		60.00
61.00 06100 RURAL HEALTH CLINIC	0	0		61. 00
62. 00 06200 FQHC				62. 00
63. 00 06300 DI ALYSI S	0	0		63. 00
OTHER REIMBURSABLE COST CENTERS				70.00
70. 00 07000 HOME HEALTH AGENCY COST 71. 00 07100 AMBULANCE	0 0			70. 00 71. 00
73. 00 07300 CMHC	0		l .	73.00
74. 00 07400 OTHER REIMBURSEMENT	0			74.00
SPECIAL PURPOSE COST CENTERS				1
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80. 00
81. 00 08100 I NTEREST EXPENSE	0	0		81. 00
82.00 08200 UTILIZATION REVIEW - SNF	0	0		82. 00
83. 00 08300 HOSPI CE	0	0		83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST I	0	0		84.00
84.01 08401 OTHER SPECIAL PURPOSE COST II 89.00 SUBTOTALS (sum of lines 1-84)	-1, 961, 746	11, 493, 876		84. 01 89. 00
NONREI MBURSABLE COST CENTERS	1, 701, 740	11, 475, 676		07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	5, 654		90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	0		91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0		92. 00
93. 00 09300 NONPALD WORKERS	0	0		93. 00
94. 00 09400 PATIENTS LAUNDRY	0	0		94. 00
95. 00 09500 OTHER NONREI MBURSABLE COST	1 041 744	11 400 530		95.00
100. 00 TOTAL	-1, 961, 746	11, 499, 530	I	100. 00

Health Financial Systems	SOME	RSET VALLEY REHAB AN	ND NURSING	CT	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS			Provi der	No.: 315002	Peri od:	Worksheet A-6	,
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Increases						
		Cost Cente	r	Li ne #	Sal ary	Non Salary	
		2.00		3.00	4. 00	5. 00	
TOTALS							
100. 00		Total Reclassificat	ions (Sum		0	0	100.00
		of columns 4 and 5					

⁽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.

Health Financial Systems	SOMERSE	T VALLEY REHAB A	ND NURSING	CT	In Lie	eu of Form CMS-	2540-10
RECLASSI FI CATI ONS			Provi der	No.: 315002	Peri od: From 01/01/2023	Worksheet A-6	1
					To 12/31/2023	Date/Time Pre 5/10/2024 11:	
				Decreases			
		Cost Cente	r	Li ne #	Sal ary	Non Salary	
		6, 00		7. 00	8. 00	9. 00	

0

0 100. 00

TOTALS

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.

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der No.: 315002

				'	0 12/01/2020	5/10/2024 11:	
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equi pment	0	0	0	0	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	0	0	0	0	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	0	0	0	0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5	_				
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6. 00	Movabl e Equi pment	0	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	0	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	0	0	l		l	9. 00

		RSET VALLEY REH			Workshoot A 9	
ADJUST	MENTS TO EXPENSES		Provi der	No.: 315002 Peri od: From 01/01/2023	Worksheet A-8	
				To 12/31/2023	Date/Time Pre	
					5/10/2024 11:	59 am
				Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	, ,	Adjustment				
		1.00	2. 00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-1, 168	CAP REL COSTS - BLDGS &	1.00	1.00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
3.00	8) Refunds and rebates of expenses (chapter 8)		0		0.00	3.00
4. 00	Rental of provider space by suppliers		0		0.00	
1. 00	(chapter 8)				0.00	1.00
5.00	Telephone services (pay stations excluded)		0		0.00	5.00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	
7.00	Parking lot (chapter 21)		0		0.00	1
8. 00	Remuneration applicable to provider-based	A-8-2	0			8. 00
0.00	physician adjustment				0.00	0.00
9. 00 10. 00	Home office cost (chapter 21) Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0		0.00	1
11.00	Capital expenditures (chapter 24)		0		0.00	11.00
12.00	Adjustment resulting from transactions with	A-8-1	-1, 729, 240			12.00
	related organizations (chapter 10)					
13.00	Laundry and linen service		0		0.00	
14.00	Revenue - Employee meals		0		0.00	1
15. 00	Cost of meals - Guests		0		0.00	1
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
17. 00	patients Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts	•	0		0.00	1
19. 00	Vending machines		0		0.00	1
20. 00	Income from imposition of interest, finance		Ö		0.00	1
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		0		0.00	21.00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
23. 00	(chapter 21) Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
23.00	bepreciationburidings and frixtures		0	FIXTURES	1.00	23.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
			_	EQUI PMENT		
25.00	RESIDENT REPLACEMENT ITEMS	A	-7, 631	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETING EXPENSE	A	-18, 158	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	MARKETING CORP EXPENSE	A		ADMINISTRATIVE & GENERAL	1	25. 02
25. 03	MARKETING - MEALS	A		ADMI NI STRATI VE & GENERAL	4.00	1
25. 04	SHOWS & CONFERENCES	A		ADMINISTRATIVE & GENERAL	4.00	1
25. 05	SPONSORSHI PS	A		ADMINISTRATIVE & GENERAL	4.00	1
25. 06	BAD DEBT EXPENSE BAD DEBT EXPENSE - MEDICARE	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	4.00	1
25. 07 25. 08	OTHER MEDICAL SERVICES EXPENSE	A A		SKILLED NURSING FACILITY	4. 00 30. 00	1
25. 06	OTHER REVENUE	B		ADMINISTRATIVE & GENERAL	4.00	1
25. 10	OTHER INCOME	В		ADMINISTRATIVE & GENERAL	4.00	1
	Total (sum of lines 1 through 99) (Transfer	_	-1, 961, 746			100.00
	to Worksheet A, col. 6, line 100)					
(4) 0						

(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.

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 Financial
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 STATEMENT
 OF
 COSTS
 OF
 SERVICES
 FROM
 RELATED
 ORGANIZATIONS
 AND
 HOME
 Provider
 No.:
 Provi der No.: 315002 OFFICE COSTS

UFFICE				Ť	o 12/31/2023 Date/Time Pre	
		Li ne No.	Cost (Center	Expense Items	
		1.00		00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00	OLAT WILD HOWLE OF FIGE COSTS.		CAP REL COSTS FLXTURES	- BLDGS &	RENT - RELATED PARTY	1. 00
2.00			ADMI NI STRATI VE	& GENERAL	ADMINISTRATIVE FEE - RELATED PARTY	2. 00
3. 00		4. 00	ADMI NI STRATI VE	& GENERAL	IT ALLOCATION - RELATED PARTY	3. 00
4. 00 5. 00			ADMINISTRATIVE NURSING ADMINI		MANAGEMENT FEES PHARMACY CONSULTANT	4. 00 5. 00
6.00			CENTRAL SERVIC		WOUND CARE EXPENSE	6.00
7. 00			PHARMACY	LS & SUFFLI	DRUGS-NON-PRESCRI PTI ON, NON-LEGEND	7. 00
8.00		11. 00	PHARMACY		PHARMACY SUPPLIES	8. 00
9.00		42. 00	INTRAVENOUS TH	ERAPY	IV EXPENSE	9. 00
9. 01			DRUGS CHARGED		DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	9. 01
9. 02		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	9. 02
9. 03		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE	9. 03
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.					10.00
	, -=-	Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col . 5)		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	4.00	5. 00	6.00	D ODCANI ZATLONC OD	
	CLAIMED HOME OFFICE COSTS:	KED AS A RESULT	UF TRANSACTIO	INS WITH RELATE	D URGANIZATIONS UR	
1.00		970, 903				1. 00
2.00		0	45, 754			2. 00
3.00		400 127	2, 356			3. 00
4. 00 5. 00		490, 137	622, 451			4. 00 5. 00
6.00		23, 971 67, 463	26, 055 67, 463	1		6.00
7. 00		9, 293	10, 101	1		7. 00
8. 00		142	154			8.00
9. 00		162, 718				9. 00
9. 01		14, 728				9. 01
9. 02		195, 390		1		9. 02
9. 03		352, 458				9. 03
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	2, 287, 203	4, 016, 443	1		10. 00
	12.	I	I	I	I	I

3.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315002 Peri od: Worksheet A-8-1 From 01/01/2023 Parts I-II Date/Time Prepared: OFFICE COSTS 12/31/2023 5/10/2024 11:59 am Symbol (1) Name Percentage of Ownershi p

2.00

1.00 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	THCI	100.00	1.00
2.00	A	THCI	100.00	2. 00
3. 00	A	THCI	100.00	3. 00
4. 00	A	CARE ONE	100.00	4. 00
5. 00			0.00	5. 00
6. 00			0.00	6. 00
7. 00			0.00	7. 00
8. 00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

- (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 rel ated 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.

	Rel ated Organi	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDE ATLANGUER TO RELATER ARRANGE	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		1621 RT 22 WEST LLC	100.00	REALTY	1. 00
2.00		HEALTHBRI DGE	100.00	HOME OFFICE	2.00
3.00		PARTNERS PHARMACY	68. 10	PHARMACY	3. 00
4.00		TOTAL CARE LLC	100.00	WOUND CARE	4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100.00
	speci fy:				

- (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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315002

					Ic	12/31/2023	Date/IIme Pre 5/10/2024 11:	
				CAPI TAL REI	ATED COSTS		07 107 2021 11.	97 4111
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		cost center bescription	for Cost	FI XTURES	EQUI PMENT	BENEFITS	Subtotai	
			Allocation	1171101120	E GOTT III ETT	JENET 10		
			(from Wkst A					
			col. 7)	1. 00	2.00	2.00	3A	
	GENER	AL SERVICE COST CENTERS	0	1.00	2. 00	3. 00	SА	
1.00		CAP REL COSTS - BLDGS & FIXTURES	1, 042, 492	1, 042, 492				1. 00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	11, 503		11, 503			2. 00
3.00		EMPLOYEE BENEFITS	1, 645, 196	34, 765		1, 680, 345		3. 00
4.00		ADMINISTRATIVE & GENERAL	1, 375, 724	44, 241		130, 878	1, 551, 331	4. 00
5. 00 6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	414, 523 103, 835	69, 530 38, 190		23, 775 20, 708	508, 595 163, 154	5. 00 6. 00
7. 00		HOUSEKEEPING	250, 313	2, 968		63, 537	316, 851	7. 00
8.00	1	DI ETARY	538, 623	202, 881		103, 577	847, 320	8. 00
9.00	00900	NURSING ADMINISTRATION	644, 974	13, 187	146	149, 011	807, 318	9. 00
10.00		CENTRAL SERVICES & SUPPLY	244, 411	6, 679		11, 263	262, 427	10.00
11. 00 12. 00		PHARMACY MEDICAL RECORDS & LIBRARY	9, 435	1 270		0 543	9, 435	11. 00 12. 00
12.00		SOCIAL SERVICE	1, 943 105, 534	1, 370 26, 145	1	29, 482	3, 871 161, 449	
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14. 00
15. 00	01500	ACTI VI TES	122, 899	0	0	34, 064	156, 963	15. 00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		SKILLED NURSING FACILITY	2, 744, 768	436, 417		753, 771	3, 939, 772	30.00
31. 00 32. 00	1	NURSING FACILITY ICF/IID		0		0	0	31. 00 32. 00
33. 00		OTHER LONG TERM CARE		0		o	0	33. 00
		LARY SERVICE COST CENTERS			,	-,		
40. 00	1	RADI OLOGY	40, 989	0		0	40, 989	40. 00
41. 00		LABORATORY	75, 327	0		0	75, 327	41. 00
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	162, 718	0	· -	0	162, 718 0	42. 00 43. 00
44. 00		PHYSI CAL THERAPY	707, 788	57, 314		193, 695	959, 429	44. 00
45. 00	1	OCCUPATIONAL THERAPY	468, 553	60, 568		130, 894	660, 683	
46. 00		SPEECH PATHOLOGY	127, 562	8, 791	97	35, 147	171, 597	46. 00
47. 00		ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	E42 E74	18, 153 3, 482		0	18, 353	48. 00 49. 00
50.00	1	DENTAL CARE - TITLE XIX ONLY	562, 576	3, 462	1	0	566, 096 0	50.00
51. 00		SUPPORT SURFACES		0		o	0	51.00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	O	0	0	0	0	52. 00
52. 01		OTHER ANCILLARY SERVICES COST	0	0		0	0	52. 01
52. 02		MEDICAL SERVICES TIENT SERVICE COST CENTERS] 0]	0	0	0	0	52. 02
60. 00		CLINIC	0	0	0	o	0	60. 00
61. 00	1	RURAL HEALTH CLINIC	l o	0		o	0	
62.00	06200							62. 00
63. 00		DI ALYSI S	0	0	0	0	0	63. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST		0	O	ol	0	70. 00
71.00	1	AMBULANCE	92, 190	0		0	92, 190	•
73. 00	07300		0	0		Ö	0	73. 00
74.00		OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
		AL PURPOSE COST CENTERS						
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00		UTILIZATION REVIEW - SNF						82. 00
83. 00		HOSPI CE	o	0	0	o	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	NONDE	SUBTOTALS (sum of lines 1-84)	11, 493, 876	1, 024, 681	11, 306	1, 680, 345	11, 475, 868	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	5, 654	0	O	ol	5, 654	90. 00
91. 00	1	BARBER AND BEAUTY SHOP	0,034	1, 713		Ö	1, 732	91. 00
92. 00		PHYSICIANS PRIVATE OFFICES		0	0	ō	0	92. 00
93. 00		NONPALD WORKERS	0	0	0	o	0	93. 00
94. 00	1	PATIENTS LAUNDRY	0	0	0	O	1/ 27/	94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST Cross Foot Adjustments		16, 098 0	1	O ₁	16, 276 0	95. 00 98. 00
99. 00		Negative Cost Centers	0	0	1	0	0	99.00
100.00)	TOTAL	11, 499, 530	1, 042, 492	11, 503	1, 680, 345	11, 499, 530	
			•		·	•		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315002

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared:

				To	12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	34 alli
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 551, 331					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	79, 311	587, 906				5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	25, 442 49, 410	25, 116		368, 213		6. 00 7. 00
8.00	00800 DI ETARY	132, 132	1, 952 133, 424	1	368, 213 87, 598	1, 200, 474	8.00
9. 00	00900 NURSING ADMINISTRATION	125, 894	8, 672	i	5, 694	1, 200, 474	9.00
10. 00	01000 CENTRAL SERVICES & SUPPLY	40, 923	4, 392		2, 884	Ö	10.00
11. 00	01100 PHARMACY	1, 471	0	1	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	604	901	0	592	0	12.00
13.00	01300 SOCIAL SERVICE	25, 177	17, 194	0	11, 289	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTIVITES	24, 477	0	0	0	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	614, 370	287, 009	213, 712	188, 431	1, 200, 474	30.00
31. 00	03100 NURSING FACILITY	014, 370	287,009	213, 712	188, 431	1, 200, 474	31.00
32. 00	03200 CF/11D		0	1	0	Ö	32.00
33. 00	03300 OTHER LONG TERM CARE	o	0	ō	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	6, 392	0	0	0	0	40. 00
41. 00	04100 LABORATORY	11, 747	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	25, 374	0	0	0	0	42.00
43. 00 44. 00	04300 0XYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	140 614	27 402	0	24 744	0	43. 00 44. 00
45. 00	04500 OCCUPATIONAL THERAPY	149, 614 103, 028	37, 692 39, 832	1	24, 746 26, 151	0	45.00
46. 00	04600 SPEECH PATHOLOGY	26, 759	5, 781	1	3, 796	Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0,751	ő	0,770	Ö	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 862	11, 938	О	7, 838	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	88, 278	2, 290	0	1, 504	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	0	0		0	0 0	52. 00 52. 01
52. 01	05201 OTHER ANCIELARY SERVICES COST		0	0	0	0	52.01
32. 02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		, 0	0	0	32.02
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	o	0	О	0	0	61.00
62.00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS				ما		70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0 14, 376	0		0	0	70. 00 71. 00
	07300 CMHC	14, 370	0		0	0	73.00
	07400 OTHER REIMBURSEMENT		0	Ö	0	Ö	74.00
	SPECIAL PURPOSE COST CENTERS	-1	-		-1		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF		_	_	_	_	82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	84. 00 84. 01
89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	1, 547, 641	576, 193	213, 712	360, 523	1, 200, 474	89.00
07.00	NONREI MBURSABLE COST CENTERS	1, 547, 641	370, 173	213,712	300, 323	1, 200, 474	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	882	0	0	O	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	270	1, 126	0	739	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	o	0	0	o	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0 500	10 505	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREI MBURSABLE COST	2, 538	10, 587		6, 951	0	95.00
98.00	Cross Foot Adjustments Negative Cost Centers		0		0	0	98. 00 99. 00
100.00		1, 551, 331	587, 906	213, 712	368, 213		
	1	, , , , , , , , , , , , , , , , , , , ,		-,	2 27 2 19	,, -, -	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315002

| Period: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: | 5/10/2024 | 11: 59 am

						5/10/2024 11:	59 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		0.00	SUPPLY 10. 00	11 00	LI BRARY	13. 00	
	GENERAL SERVICE COST CENTERS	9. 00	10.00	11. 00	12. 00	13.00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						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 HOUSEKEEPI NG						7.00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	947, 578					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	310, 626				10.00
11. 00	01100 PHARMACY	0	0.0,020	10, 906			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	o	0	0	5, 968	•	12.00
13. 00	01300 SOCIAL SERVICE	o	0	0	0	215, 109	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	0	0	0	14. 00
15.00	01500 ACTI VI TES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	947, 578	310, 626	10, 906	5, 968	215, 109	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	0	0	0	1 40 00
40. 00 41. 00	04100 LABORATORY		0	0	0	0 0	40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY		0	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	o o	0	Ö	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	Ö	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	Ō	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
40.00	OUTPATIENT SERVICE COST CENTERS		0		0	0	(0.00
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		U	U	U	U	62.00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63.00
00.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>	J		00.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00	07100 AMBULANCE	O	0	0	0	0	71.00
73.00	07300 CMHC	0	0	0	0	0	73. 00
74.00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	-	210 424	10, 906	5, 968		84. 01 89. 00
69.00	NONREI MBURSABLE COST CENTERS	947, 578	310, 626	10, 900	3, 900	215, 109	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	o o	0	ő	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	Ö	92.00
93. 00	09300 NONPALD WORKERS		0	o	Ö	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0	0				98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00) TOTAL	947, 578	310, 626	10, 906	5, 968	215, 109	100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315002

				'	0 12/31/2023	5/10/2024 11:	
			OTHER GENERAL				
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TES	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION	15.00	1/ 00	17.00	10.00	
	GENERAL SERVICE COST CENTERS	14.00	15. 00	16. 00	17. 00	18. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						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 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
	01200 MEDICAL RECORDS & LIBRARY						12. 00
	01300 SOCIAL SERVICE						13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTI VI TES	0	181, 440				15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		101 110	0 445 005		0.445.005	00.00
30.00	03000 SKILLED NURSING FACILITY	0	181, 440	8, 115, 395		8, 115, 395	30.00
	03100 NURSING FACILITY	0	0		0	0	31.00
32. 00 33. 00	03200 1 CF/11 D	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0		0	0	33. 00
40. 00	04000 RADI OLOGY	0	0	47, 381	O	47, 381	40. 00
41. 00	04100 LABORATORY	0	0			87, 074	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	188, 092		188, 092	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	100, 072	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	1, 171, 481	0	1, 171, 481	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	829, 694	-	829, 694	1
46. 00	04600 SPEECH PATHOLOGY	0	0	207, 933		207, 933	
	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	40, 991	0	40, 991	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	658, 168	0	658, 168	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	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
(0.00	OUTPATIENT SERVICE COST CENTERS	_				0	
	06000 CLINIC	0	0			0	
61.00	06100 RURAL HEALTH CLINIC	0	U	U	0	0	61.00
62. 00 63. 00	06200 FQHC 06300 DI ALYSI S	0	0	0	0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	0	0		U U	U	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
	07100 AMBULANCE	0					
	07300 CMHC	0	0	0		0	1
	07400 OTHER REIMBURSEMENT	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	181, 440	11, 452, 775	0	11, 452, 775	89. 00
00.00	NONREI MBURSABLE COST CENTERS	1 ~	_	, 501		, 501	00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	6, 536		6, 536	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	3, 867	0	3, 867	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0			0	92. 00 93. 00
93.00	09400 PATI ENTS LAUNDRY		0			0	93.00
	09500 OTHER NONREIMBURSABLE COST		0	36, 352		36, 352	1
98. 00	Cross Foot Adjustments		n	JU, 302		0 30, 352	1
99. 00	Negative Cost Centers	0	n		n	0	99.00
100.00	1 9	0	181, 440	11, 499, 530	0		•
	1	,			-1		'

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS SOMERSET VALLEY REHAB AND NURSING CT Provi der No.: 315002

				10) 12/31/2023	5/10/2024 11:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FIXTURES	EQUI PMENT		BENEFI TS	
		Related Costs					
		0	1.00	2. 00	2A	3. 00	
	GENERAL SERVICE COST CENTERS	- 1					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT					I	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	34, 765		35, 149	35, 149	3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	0	44, 241	488	44, 729		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	69, 530		70, 297	497	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	38, 190		38, 611	433	6. 00
7.00	00700 HOUSEKEEPI NG	0	2, 968		3, 001	1, 329	7. 00
8.00	00800 DI ETARY	0	202, 881	2, 239	205, 120		8.00
9. 00 10. 00	00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0	13, 187 6, 679		13, 333 6, 753	3, 117 236	9. 00 10. 00
11. 00	01100 PHARMACY		0, 07 9	74	0, 753	0	11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	1, 370	-	1, 385	11	12.00
13. 00	01300 SOCI AL SERVI CE	l ol	26, 145		26, 433	617	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TES	0	0	0	o	713	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	436, 417	4, 816	441, 233	15, 766	30. 00
31. 00	03100 NURSING FACILITY	0	0	_	0	0	31.00
32. 00	03200 I CF/IID	0	0	0	0	0	32. 00 33. 00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	l o	0	l ol	υ	0	33.00
40. 00	04000 RADI OLOGY	0	0	0	O	0	40. 00
41. 00	04100 LABORATORY	l ol	0	Ö	ol	Ö	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	o	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	o	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	57, 314		57, 946		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	60, 568		61, 236		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	8, 791	97	8, 888		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	10 153	0	10 252	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	18, 153 3, 482		18, 353 3, 520	0 0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		3, 462 0	0	3, 520	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	0	o	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	Ö	Ö	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	o	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS				_1	_	
60.00	06000 CLINIC	0	0	0	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	U	O	0	61. 00 62. 00
63.00	06300 DI ALYSI S	0	0	0	0	0	63.00
03. 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		١	<u> </u>		05.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00	07100 AMBULANCE	0	0	0	o	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REI MBURSEMENT	0	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS	T T		ı			00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE					I	80. 00 81. 00
81.00	08200 UTI LI ZATI ON REVI EW - SNF					I	81.00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	o o	0	Ö	ő	Ö	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	o	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 024, 681	11, 306	1, 035, 987	35, 149	89. 00
	NONREI MBURSABLE COST CENTERS			,			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	1, 713	19	1, 732	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES		0	0	0	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0		0	0	93. 00 94. 00
95.00	09500 OTHER NONREI MBURSABLE COST		16, 098	178	16, 276	_	95.00
98. 00	Cross Foot Adjustments		.5,570		.5, 2, 0	ı	98. 00
99. 00	Negative Cost Centers		0	0	o	0	99. 00
100.00	D TOTAL	0	1, 042, 492	11, 503	1, 053, 995	35, 149	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS SOMERSET VALLEY REHAB AND NURSING CT Provi der No.: 315002

				T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	0 7 diii
		& GENERAL	OPERATION,	LINEN SERVICE			
			MAINT. & REPAIRS				
		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 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	47, 467					3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	2, 427	73, 221				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	778	3, 128	1			6. 00
7.00	00700 HOUSEKEEPI NG	1, 512	243	0	6, 085		7. 00
8.00	00800 DI ETARY	4, 043	16, 617		1, 448	229, 395	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	3, 852	1, 080		94	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	1, 252 45	547 0		48	0 0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	18	112	_	10	0	12.00
13. 00	01300 SOCI AL SERVI CE	770	2, 141		187	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	749	0	0	0	0	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10.000	25 747	12.050	2 112	220, 205	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	18, 800	35, 747 0	1	3, 112	229, 395 0	30. 00 31. 00
32. 00	03200 CF/11D		0	· -	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		0	o o	0	ő	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	196	0	0	0	0	40. 00
41. 00	04100 LABORATORY	359	0	0	0	0	41.00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	776	0	0	0	0	42. 00 43. 00
44. 00	04400 PHYSICAL THERAPY	4, 577	4, 694	0	409	0	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	3, 152	4, 961		432	Ö	45. 00
46. 00	04600 SPEECH PATHOLOGY	819	720	1	63	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	1	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	88	1, 487		130	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	2, 701	285 0		25	0	49.00
50. 00 51. 00	05100 SUPPORT SURFACES	0	0		0	0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		0		0	Ö	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS			-	_		
60.00	06000 CLINIC	0	0	1	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	١	U	,	U	0	61. 00 62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	-1	-				
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
	07100 AMBULANCE	440	0	0	0	-	71. 00
	07300 CMHC 07400 OTHER REIMBURSEMENT	0	0	0	0	0	1
74.00	SPECIAL PURPOSE COST CENTERS	l ol) 0	U	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II	47 254	71, 762	0 42, 950	U = 0=0	0 229, 395	84. 01
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	47, 354	/1, /02	42, 950	5, 958	229, 393	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	27	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	8	140	0	12	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	78	0 1, 319	0	0 115	0 0	94. 00 95. 00
95. 00 98. 00	Cross Foot Adjustments	/8	1, 319		112	0	98.00
99. 00	Negative Cost Centers	0	0	ol ő	0	0	99. 00
100.00		47, 467	73, 221	42, 950	6, 085	-	
		·					

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315002

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/10/2024 | 11:59 am

						5/10/2024 11:	<u>59 am</u>
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
	1	21 47/					•
9.00	00900 NURSI NG ADMI NI STRATI ON	21, 476					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	U	8, 836				10.00
11. 00	01100 PHARMACY	0	0	45			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	1, 536		12. 00
13. 00	01300 SOCI AL SERVI CE	0	0	0	0	30, 148	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	21, 476	8, 836	45	1, 536	30, 148	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/IID	o	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	o	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS				-		
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	o	0	0	0	Ö	41. 00
42. 00	04200 I NTRAVENOUS THERAPY		0	0	0	Ö	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY		0	0	0	0	44. 00
		0	0	0	0		•
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	o	0	0	0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	o	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	l ol	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS				-		
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	o	0	i o	0	0	61. 00
62. 00	06200 FQHC		O	J	O	·	62.00
63. 00	06300 DI ALYSI S	o	0	0	0	0	63.00
03.00	OTHER REIMBURSABLE COST CENTERS	J U		l U	U	0	03.00
70.00		1 0			0	0	70 00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	0	0	0	0	0	71.00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE	0	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	o	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	o	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	21, 476	8, 836	45	1, 536	30, 148	89. 00
	NONREI MBURSABLE COST CENTERS		-,		.,		1
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	o	0	0	0	Ö	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES		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	94.00
95.00	09500 OTHER NONREIMBURSABLE COST		0] 0 0	0	0	
	i i		0		U		95.00
98. 00	Cross Foot Adjustments	0	0	0		_	98. 00
99. 00	Negative Cost Centers	0 0	0	0	4 50	0	99.00
100.00) TOTAL	21, 476	8, 836	45	1, 536	30, 148	1100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315002

				'	0 12/31/2023	5/10/2024 11:	
			OTHER GENERAL				
	Cost Contor Doscription	NURSI NG AND	SERVI CE ACTI VI TES	Subtotal	Post Step-Down	Total	
	Cost Center Description	ALLI ED HEALTH	ACTIVITES	Subtotal	Adjustments	Total	
		EDUCATI ON			naj astments		
		14.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS		T				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 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 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9. 00 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 ACTIVITES	0	1, 462				15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0	1, 462	850, 506	0	850, 506	30.00
31. 00	03100 NURSING FACILITY	0	1, 462			030, 300	31.00
32. 00	03200 CF/IID		0			0	1
33. 00	03300 OTHER LONG TERM CARE	0	0			0	1
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	1			196	1
41. 00	04100 LABORATORY	0	0			359	1
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0	776 0		776 0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	71, 678		71, 678	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	72, 519		72, 519	1
46.00	04600 SPEECH PATHOLOGY	0	0			11, 225	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	_	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20, 058		20, 058	1
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0	6, 531	0	6, 531	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	Ö	l	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	
62. 00	06200 FQHC		0	0	U	0	61. 00 62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	1
	OTHER REIMBURSABLE COST CENTERS			-			1
	07000 HOME HEALTH AGENCY COST	0				0	
	07100 AMBULANCE	0					71.00
73.00	07300 CMHC	0	1				1
74. 00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS				U	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0		0	1
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	_	0	
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II	0	1 442	1, 034, 288	0	0 1, 034, 288	
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	1, 462	1, 034, 200	U	1, 034, 200	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	Ιο	0	27	0	27	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	1, 892		1, 892	1
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0		0	92.00
93.00	09300 NONPAI D WORKERS	0	0	0	_	0	1
94. 00	09400 PATIENTS LAUNDRY	0	0	17 700	-	17.700	
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments			17, 788 0		17, 788 0	1
99. 00	Negative Cost Centers	0	0		-	0	1
100.00	1 1 0	0	1, 462		-		
		•					•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315002

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Pre

Date/Time Prepared: 5/10/2024 11:59 am CAPITAL RELATED COSTS BLDGS & MOVABLE **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description **FLXTURES FOUL PMENT** BENEFITS & GENERAL (SQUARE FEET) (SQUARE FEET) (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 4A 4.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 18, 262 1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 18, 262 2.00 3.00 00300 EMPLOYEE BENEFITS 609 609 6, 015, 010 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 775 775 468, 495 -1, 551, 331 9, 948, 199 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 508, 595 5 00 85, 107 5 00 1 218 1, 218 00600 LAUNDRY & LINEN SERVICE 6.00 669 669 74, 127 0 163, 154 6.00 7.00 00700 HOUSEKEEPI NG 52 52 227, 440 316, 851 7.00 00800 DI ETARY 370, 768 0 847, 320 8.00 8 00 3 554 3 554 00900 NURSING ADMINISTRATION 9.00 231 231 533, 403 807, 318 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 117 117 40, 318 262, 427 10.00 01100 PHARMACY 0 9, 435 11.00 11.00 0 C 01200 MEDICAL RECORDS & LIBRARY 1. 943 24 24 12 00 3 871 12 00 13.00 01300 SOCIAL SERVICE 458 458 105, 534 161, 449 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 0 14.00 01500 ACTI VI TES 15.00 0 121, 936 156, 963 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 7,645 7, 645 2, 698, 218 0 3, 939, 772 30.00 03100 NURSING FACILITY 0 31.00 31.00 03200 | CF/IID 0 0 0 32.00 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40, 989 40.00 0 41.00 04100 LABORATORY 0 0 75, 327 41.00 0 04200 I NTRAVENOUS THERAPY O 42.00 0 C 162, 718 42 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 0 43.00 04400 PHYSI CAL THERAPY 44.00 1,004 1,004 693, 356 0 959, 429 44.00 04500 OCCUPATIONAL THERAPY 1,061 1,061 45.00 468, 553 660, 683 45.00 46.00 04600 SPEECH PATHOLOGY 154 154 125, 812 171, 597 46.00 04700 ELECTROCARDI OLOGY 47.00 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 318 318 0 0 18, 353 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49 00 61 61 566, 096 49 00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 C 0 0 50.00 0 51.00 05100 SUPPORT SURFACES 0 0 0 Ω 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 52.00 52.00 C 0 05201 OTHER ANCILLARY SERVICES COST 0 52.01 0 C 0 0 52.01 52.02 05202 MEDICAL SERVICES 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 60.00 60.00 0 Ω Ω 0 Λ 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 DI ALYSI S 63.00 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 0 0 71.00 07100 AMBULANCE 0 0 92, 190 71.00 73 00 107300 CMHC 0 Ω 0 0 73 00 0 74.00 07400 OTHER REIMBURSEMENT 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81 00 81 00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 84.00 08401 OTHER SPECIAL PURPOSE COST II 84.01 0 0 84 01 89.00 SUBTOTALS (sum of lines 1-84) 17, 950 17, 950 6, 015, 010 -1, 551, 331 9, 924, 537 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 5, 654 90.00 90.00 C 0 09100 BARBER AND BEAUTY SHOP 0 91.00 30 30 1.732 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 92.00 C 93.00 09300 NONPALD WORKERS 0 0 0 0 93.00 0 O 09400 PATIENTS LAUNDRY 94.00 0 0 0 94 00 95.00 09500 OTHER NONREIMBURSABLE COST 282 282 0 16, 276 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, 1,042,492 11, 503 1, 680, 345 1, 551, 331 102. 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 57.085314 0.629887 0.279359 0. 155941 103. 00 104.00 Cost to be allocated (per Wkst. B, 35, 149 47, 467 104. 00 Part II)

Health Financial Systems SOME	RSET VALLEY REF	IAB AND NURSING	CT	In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2023 Fo 12/31/2023		
	CAPITAL REI	LATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
			SALARI ES)			
	1.00	2. 00	3. 00	4A	4.00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 005844	1	0. 004771	105. 00

Heal th	Financial Systems SOMEF	RSET VALLEY REH	IAB AND NURSING	СТ	In Lie	eu of Form CMS-	2540-10
	LLOCATION - STATISTICAL BASIS	TOE! THEEE! HE!			eri od:	Worksheet B-1	
					rom 01/01/2023	D 1 (T' D	
				T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	37 aiii
	'	OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
			(PATIENT DAYS)				
		REPAI RS				(PATIENT DAYS)	
		(SQUARE FEET)	/ 00	7.00	0.00	0.00	
	CENEDAL SERVICE COST CENTEDS	5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FLXTURES						1.00
	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
	00300 EMPLOYEE BENEFITS						3. 00
	00400 ADMINISTRATIVE & GENERAL						4. 00
	00500 PLANT OPERATION, MAINT. & REPAIRS	15, 660					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	669	l .				6. 00
7.00	00700 HOUSEKEEPI NG	52	0	14, 939			7. 00
	00800 DI ETARY	3, 554	0	3, 554	56, 139		8. 00
	00900 NURSING ADMINISTRATION	231		231		18, 713	9. 00
	01000 CENTRAL SERVICES & SUPPLY	117		117		0	
	01100 PHARMACY	0		0		0	
	01200 MEDI CAL RECORDS & LI BRARY	24	l .	24		0	
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	458 0		458 0		0	13. 00 14. 00
	01500 ACTIVITES				-	0	1
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		U	0	15.00
30. 00	03000 SKILLED NURSING FACILITY	7, 645	18, 713	7, 645	56, 139	18, 713	30. 00
	03100 NURSING FACILITY	0		1		0	1
	03200 CF/IID	0				Ö	
	03300 OTHER LONG TERM CARE	0			_		
	ANCILLARY SERVICE COST CENTERS	'				<u>'</u>	1
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	
	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	
	04400 PHYSI CAL THERAPY	1, 004		1, 004		0	
	04500 OCCUPATI ONAL THERAPY	1, 061	l .	1, 061		0	
	04600 SPEECH PATHOLOGY	154		154		0	46. 00
	04700 ELECTROCARDI OLOGY	318		0 318	_	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	61		61	0	0	48. 00 49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	01	0	0	0	0	50.00
	05100 SUPPORT SURFACES			0	0	0	1
	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	Ö	1
	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	1
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
	06000 CLI NI C	0	l .			0	
	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
	06200 FQHC						62. 00
	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS				0		70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	-			0	
	07300 CMHC	0	0		_		
	07400 OTHER REIMBURSEMENT		0			l	1
	SPECIAL PURPOSE COST CENTERS			·	J	<u> </u>	74.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 H0SPI CE	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)	15, 348	18, 713	14, 627	56, 139	18, 713	89. 00
	NONREI MBURSABLE COST CENTERS	1	1		I		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	
	09100 BARBER AND BEAUTY SHOP	30	0	30		0	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	
	O9300 NONPALD WORKERS O9400 PATLENTS LAUNDRY	0	0	0	0	0	
	09500 OTHER NONREIMBURSABLE COST	282		282	0	0	1
98. 00	Cross Foot Adjustments	202		202	O	l o	98. 00
99. 00	Negative Cost Centers						99. 00
102.00		587, 906	213, 712	368, 213	1, 200, 474	947, 578	1
	Part I)		,		. ===,		
103.00	l '	37. 541890	11. 420510	24. 647768	21. 383958	50. 637418	103. 00
104.00	Cost to be allocated (per Wkst. B,	73, 221					104. 00
	Part II)						
105.00		4. 675670	2. 295196	0. 407323	4. 086197	1. 147651	105. 00
		1	I	l		l	<u> </u>

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315002

Peri od: Worksheet B-1 From 01/01/2023

12/31/2023 Date/Time Prepared: 5/10/2024 11:59 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND RECORDS & ALLI ED HEALTH SERVICES & (PATIENT DAYS) **SUPPLY** LI BRARY (PATIENT DAYS) **EDUCATION** (PATLENT DAYS) (PATLENT DAYS) (ASSI GNED TIME) 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 18,713 10.00 11.00 01100 PHARMACY 18, 713 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 18, 713 12.00 01300 SOCIAL SERVICE 18, 713 13 00 0 13 00 C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 ACTI VI TES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 18, 713 18, 713 18, 713 18, 713 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 0 33 00 33.00 Ω 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 C 0 0 41.00 04100 LABORATORY 0 0 0 0 41.00 000000000000 04200 I NTRAVENOUS THERAPY 0 42 00 42 00 Ω 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 49.00 0 49.00 0 0 0 50.00 0 50.00 05100 SUPPORT SURFACES 51.00 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 52.00 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 52.01 C 0 05202 MEDICAL SERVICES 52.02 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 Ω 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 0 63.00 0 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 71.00 0 o 73.00 07300 CMHC C 0 73.00 0 07400 OTHER REIMBURSEMENT 0 74.00 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 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 84 01 0 SUBTOTALS (sum of lines 1-84) 89.00 18, 713 18, 713 18, 713 18, 713 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 0 09100 BARBER AND BEAUTY SHOP 0 91 00 0 0 91 00 Ω 0 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 09300 NONPALD WORKERS 0 0 0 93.00 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 95.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 310, 626 10, 906 5, 968 215, 109 0 102, 00 102.00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 16. 599476 0.582803 0.318923 11. 495164 0. 000000 103. 00 104.00 Cost to be allocated (per Wkst. B, 8,836 1,536 30, 148 0 104.00 Part II) 105 00 Unit cost multiplier (Wkst. B, Part 0 472185 0 002405 0.082082 1 611073 0.000000 105.00 111)

		ERSET VALLEY REHAB			u of Form CMS-2540-1
COST A	ALLOCATION - STATISTICAL BASIS		Provi der No.: 315002	Peri od: From 01/01/2023	Worksheet B-1
				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:59 am
	Cost Center Description	OTHER GENERAL SERVICE ACTIVITES (PATIENT DAYS)			371072024 11. 37 dill
	GENERAL SERVICE COST CENTERS	15. 00			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00	00300 EMPLOYEE BENEFITS				3. 00
4.00	00400 ADMINISTRATIVE & GENERAL				4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE				5. 00
7. 00	00700 HOUSEKEEPI NG				7. 00
8.00	00800 DI ETARY				8. 00
9.00	00900 NURSING ADMINISTRATION				9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY				10.00
	01200 MEDICAL RECORDS & LIBRARY				11.00
	01300 SOCI AL SERVI CE				13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION				14.00
15. 00		18, 713			15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	10 712			20.00
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	18, 713			30. 00 31. 00
					32.00
	03300 OTHER LONG TERM CARE	Ö			33.00
	ANCILLARY SERVICE COST CENTERS				
		0			40.00
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0			41.00
	04300 OXYGEN (INHALATION) THERAPY	0			43.00
	04400 PHYSI CAL THERAPY	0			44.00
	04500 OCCUPATI ONAL THERAPY	0			45. 00
	04600 SPEECH PATHOLOGY	0			46. 00
	04700 ELECTROCARDI OLOGY	0			47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0			48. 00 49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0			50.00
51.00	05100 SUPPORT SURFACES	O			51.00
	05200 COMPLEX MEDICAL EQUIPMENT	0			52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0			52. 01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0			52. 02
60. 00	06000 CLINIC	0			60.00
61. 00	06100 RURAL HEALTH CLINIC	0			61.00
62.00	06200 FQHC	_			62.00
63. 00	06300 DI ALYSI S	0			63.00
70. 00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	0			70.00
	07100 AMBULANCE	0			71. 00
73. 00	07300 CMHC	0			73.00
74. 00	07400 OTHER REI MBURSEMENT	0			74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES				80. 00
	08100 INTEREST EXPENSE				81. 00
	08200 UTI LI ZATI ON REVI EW - SNF				82.00
	08300 HOSPI CE	0			83.00
	08400 OTHER SPECIAL PURPOSE COST I	0			84.00
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0 18, 713			84. 01 89. 00
57.00	NONREI MBURSABLE COST CENTERS	10, / 13			07. 00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90.00
	09100 BARBER AND BEAUTY SHOP	0			91. 00
92. 00 93. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0			92.00
94.00	09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY				94. 00
	09500 OTHER NONREIMBURSABLE COST	o o			95. 00
98. 00	Cross Foot Adjustments				98.00
99.00	Negative Cost Centers	104			99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	181, 440			102. 00
103.00		9. 695933			103. 00
104.00		1, 462			104. 00
405 -	Part II)				
105.00	Unit cost multiplier (Wkst. B, Part	0. 078128			105. 00
	1111				

Heal thFinancialSystemsSOMERSETVALLEYREHALRATIO OF COST TOCHARGESFOR ANCILLARY AND OUTPATIENT COST CENTERS In Lieu of Form CMS-2540-10 Period: From 01/01/2023 Provi der No.: 315002 Worksheet C

		Ť	0 12/31/2023	Date/Time Prep 5/10/2024 11:5	
	Cost Center Description	Total (from	Total Charges	Ratio (col. 1	, diii
	'	Wkst. B, Pt I,	3	di vi ded by	
		col . 18)		col. 2	
		1.00	2. 00	3. 00	
	NCILLARY SERVICE COST CENTERS				
40.00 0	4000 RADI OLOGY	47, 381	102, 472	0. 462380	40.00
	4100 LABORATORY	87, 074	188, 318	0. 462377	41.00
42.00 0	4200 INTRAVENOUS THERAPY	188, 092	442, 168	0. 425386	42.00
43.00 0	4300 OXYGEN (INHALATION) THERAPY	C	0	0.000000	43.00
44.00 0	4400 PHYSI CAL THERAPY	1, 171, 481	2, 913, 180	0. 402131	44.00
45.00 0	4500 OCCUPATI ONAL THERAPY	829, 694	2, 839, 868	0. 292159	45.00
46.00 0	4600 SPEECH PATHOLOGY	207, 933	486, 612	0. 427308	46.00
47.00 0	4700 ELECTROCARDI OLOGY	C	0	0.000000	47.00
48.00 0	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 991	0	0.000000	48.00
49.00 0	4900 DRUGS CHARGED TO PATIENTS	658, 168	1, 528, 737	0. 430531	49.00
50.00 0	5000 DENTAL CARE - TITLE XIX ONLY	C	0	0.000000	50.00
51.00 0	5100 SUPPORT SURFACES	C	0	0.000000	51.00
52.00 0	5200 COMPLEX MEDICAL EQUIPMENT	C	0	0.000000	52.00
52. 01 0	5201 OTHER ANCILLARY SERVICES COST	C	0	0.000000	52. 01
52.02 0	5202 MEDI CAL SERVI CES	C	0	0.000000	52.02
	UTPATIENT SERVICE COST CENTERS				
	6000 CLI NI C	C	0	0.000000	60.00
61.00 0	6100 RURAL HEALTH CLINIC				61.00
	6200 FQHC				62.00
63.00 0	6300 DI ALYSI S	C	0	0.000000	63.00
	7100 AMBULANCE	106, 566		0. 462376	
100.00	Total	3, 337, 380	8, 731, 830		100. 00

		RSET VALLEY REF				eu of Form CMS-	2540-10
APPORT	TIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315002	Peri od:	Worksheet D	
					From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/10/2024 11:	
			Title	XVIII (1)	Skilled Nursing		<u> </u>
				()	Facility		
			Health Care Pr	rogram Charge	s Health Care	Program Cost	
						l	
		Ratio of Cost	Part A	Part B		Part B (col. 1	
		to Charges			x col. 2)	x col. 3)	
		(Fr. Wkst. C					
		Col umn 3) 1.00	2.00	3.00	4. 00	5. 00	
	PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS	IENI COSI					-
40. 00	04000 RADI OLOGY	0. 462380	23, 235		0 10, 743	0	40. 00
41. 00	04100 LABORATORY	0. 462377			0 19, 719		
	04200 NTRAVENOUS THERAPY	0. 425386			0 17,717	0	
	04300 OXYGEN (INHALATION) THERAPY	0. 000000				0	1
	04400 PHYSI CAL THERAPY	0. 402131			0 652, 287		
45. 00	04500 OCCUPATI ONAL THERAPY	0. 292159			0 458, 628		
46. 00	04600 SPEECH PATHOLOGY	0. 427308			0 125, 888		
47. 00	04700 ELECTROCARDI OLOGY	0. 000000			0 123,000	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	0. 430531			0 94, 199	_	
	05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			71,177	Ĭ	50.00
	05100 SUPPORT SURFACES	0. 000000			0	0	1
	05200 COMPLEX MEDICAL EQUIPMENT	0. 000000			0 0	Ö	
	05201 OTHER ANCI LLARY SERVICES COST	0. 000000			0 0	Ö	
	05202 MEDI CAL SERVI CES	0. 000000			0 0		1
02.02	OUTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>		02.02
60.00		0. 000000	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC						61.00
62.00	06200 FQHC						62. 00
	06300 DI ALYSI S	0. 000000	0		0 0	0	63.00
71.00	07100 AMBULANCE (2)	0. 462376			0	0	71. 00
100.00	Total (Sum of lines 40 - 71)		3, 771, 150		0 1, 361, 464	0	100. 00
(4) =	- +: +! - V VIV ! 1 2 1						

(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.

Heal th	Financial Systems SOMER	RSET VALLEY REH	IAB AND NURSING	СТ	In Lie	eu of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315002	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 59 am
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1.00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1. 00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C column 3	line 49)	0. 430531	1.00
2. 00	Program vaccine charges (From your reco			t o, corumir s	, 11110 47)	0. 430331	2.00
3.00	Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet		
0.00	E, Part I, line 18)	л,о р. о	40. 0, 4. 4. 5.	or trino amoun	t to normanast		0.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
			Allied Health		Cost (From	& Allied	
			(From Wkst. B,			Health Costs	
		18		Costs to Tota		for Pass	
				Costs - Part		Through (Col.	
				(Col . 2 / Col		3 x Col . 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS			0.00	1. 00	0.00	
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	47, 381	0	0.00000	00 10, 743	0	40. 00
41.00	04100 LABORATORY	87, 074	0	0.00000	19, 719	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	188, 092	0	0.00000	0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0.00000	00	0	43. 00
44.00	04400 PHYSI CAL THERAPY	1, 171, 481	0	0.00000		0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	829, 694		0. 00000			45. 00
46.00	04600 SPEECH PATHOLOGY	207, 933	0	0. 00000			46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0. 00000		0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 991	0	0. 00000		0	
	04900 DRUGS CHARGED TO PATIENTS	658, 168	0	0. 00000			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000		0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0.00000		0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT			0.00000		0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES	0	0	0. 00000 0. 00000		0	
52. 02 100. 00		3, 230, 814	ľ		1, 361, 464	0	100.00
100.00	Total (Suil of Titles 40 - 52)	3, 230, 614	1	1	1, 301, 404	, 0	1100.00

	Financial Systems SOMERSET VALLEY RETAILOR OF INPATIENT ROUTINE COSTS	Provi der No.: 315002	Peri od:	u of Form CMS-2 Worksheet D-1	2340 1
JUNIPU	ATION OF INPATIENT ROUTINE COSTS	Provider No 315002	From 01/01/2023	Parts I-II	
			To 12/31/2023	Date/Time Pre	
		Title XVIII	Skilled Nursing	5/10/2024 11: PPS	59 alli
			Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			18, 713	1.0
. 00	Private room days			0	2. 0
. 00	Inpatient days including private room days applicable to t			11, 470 0	
. 00					4. 0
. 00	3 1			8, 115, 395	5. 0
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			9, 914, 631	6. C
. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line	5 divided by line 6)		0. 818527	7. 0
. 00	Enter private room charges from your records	e 3 di vi ded by Title 0)		0.010327	8. 0
. 00	Average private room per diem charge (Private room charges	: line 8 divided by private	room days line	0.00	
. 00	2)	or time of all vided by private	room days, rrine	0.00	,. (
0. 00	Enter semi-private room charges from your records			0	10. (
1. 00	Average semi-private room per diem charge (Semi-private r	room charges line 10, divide	d by	0.00	11. (
	semi-private room days)				
2. 00	Average per diem private room charge differential (Line 9			0. 00	
3.00	Average per diem private room cost differential (Line 7 ti			0.00	
4.00	Private room cost differential adjustment (Line 2 times li		minus lins 14)	8, 115, 395	14. (
5. 00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus ime 14)	8, 115, 395	15.0
6. 00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		433. 68	16. (
7. 00	Program routine service cost (Line 3 times line 16)			4, 974, 310	17. (
8. 00	Medically necessary private room cost applicable to progra			0	18. (
9. 00	Total program general inpatient routine service cost (Lir			4, 974, 310	
0. 00	Capital related cost allocated to inpatient routine service	ce costs (From Wkst. B, Par	t II column 18,	850, 506	20. 0
1. 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1)		45. 45	21. (
2. 00	Program capital related cost (Line 3 times line 21)			521, 312	
3. 00	Inpatient routine service cost (Line 19 minus line 22)			4, 452, 998	
4. 00	Aggregate charges to beneficiaries for excess costs (From	n provider records)		0	24.
5. 00	Total program routine service costs for comparison to the	cost limitation (Line 23 mi	nus line 24)	4, 452, 998	25.
5. 00	Enter the per diem limitation (1)				26.
7. 00	Inpatient routine service cost limitation (Line 3 times th				27. (
8. 00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, line 4) (See instruction		line 27)		28. (
i) Li	nes 26 and 27 are not applicable for title XVIII, but may be	•	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH C	OSTS FOR PPS PASS-THROUGH		55	
00	Total SNF inpatient days			18, 713	
$\cap \cap$	Program innations days (see instructions)			11 /70	2 0

Program inpatient days (see instructions)
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)
Nursing & allied health ratio. (line 2 divided by line 1)
Program nursing & allied health costs for pass-through. (line 3 times line 4)

2. 00 3. 00 4. 00 5. 00

	Financial Systems ATION OF INPATIENT ROUTINE COSTS SOMERSET VALLEY REHAB	AND NURSING CT Provi der No.: 315002	In Lie	u of Form CMS-2 Worksheet D-1	
Jiii 0 11	THE OF THE PROPERTY OF THE SOCIETY	11001461 1101 1101	From 01/01/2023 To 12/31/2023	Parts I-II Date/Time Pre 5/10/2024 11:	pared
		Title XIX	Skilled Nursing Facility	0, 10, 2021	0, 41
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS		,		
	INPATIENT DAYS				١.
00	Inpatient days including private room days		18, 713	1	
00 00	Private room days Inpatient days including private room days applicable to the	Dragram		0	1
	Medically necessary private room days applicable to the Progr			0	1
00	Total general inpatient routine service cost	ani		8, 115, 395	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0, 110, 070	1 .
00	General inpatient routine service charges			9, 914, 631	6
OO General inpatient routine service cost/charge ratio (Line 5 divided by line 6)				0. 818527	7
OD Enter private room charges from your records				0.00	
00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)				9
00 Enter semi-private room charges from your records					10
.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)					11
00	Average per diem private room charge differential (Line 9 min	nus line 11)		0.00	12
	Average per diem private room cost differential (Line 7 times			0.00	
	Private room cost differential adjustment (Line 2 times line			0	
00	General inpatient routine service cost net of private room co	ost differential (Line 5	minus line 14)	8, 115, 395	15
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 di	vided by Line 1)		433. 68	16
	Program routine service cost (Line 3 times line 16)	vided by Title 1)		433.00	
	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	1
	Total program general inpatient routine service cost (Line 1			0	
	Capital related cost allocated to inpatient routine service cline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		t II column 18,	850, 506	20
00	Per diem capital related costs (Line 20 divided by line 1)			45. 45	21
	Program capital related cost (Line 3 times line 21)			0	22
	Inpatient routine service cost (Line 19 minus line 22)			0	
	Aggregate charges to beneficiaries for excess costs (From pr			0	1
	Total program routine service costs for comparison to the cos	st limitation (Line 23 mi	nus line 24)	0	1
	Enter the per diem limitation (1)		2() (1)	0.00	
00	Inpatient routine service cost limitation (Line 3 times the p Reimbursable inpatient routine service costs (Line 22 plus t		, · · /	0	1 -
UU	(Transfer to Worksheet E, Part II, line 4) (See instructions)		1111e 2/)	0	28

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	18, 713	1.00
2.00	Program inpatient days (see instructions)	0	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.000000	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	SOMERSET \	VALLEY REHAB AND NURSING CT	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT	SETTLEMENT FOR TITLE XVIII	Provi der No.: 315002	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:59 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT	<u>'</u>		
1.00	Inpatient PPS amount (See Instructions)			8, 763, 340	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			8, 763, 340	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			1, 079, 000	5.00
6.00	Allowable bad debts (From your records)			81, 789	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			53, 163	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)			7, 737, 503	11.00
12.00	Interim payments (See instructions)			7, 635, 872	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			1, 063	14. 75
14. 99	Sequestration amount (see instructions)			153, 687	
15. 00	Balance due provider/program (see Instructions)			-53, 119	15.00
16. 00	Protested amounts (Nonallowable cost report items in accordance			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	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00				0	26. 00
27. 00	,			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)	a with CMS Dub 15 2	coction 11E 2	0	
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with two Pub. 15-2,	SECTION 115. Z	0	30. 00

Health Financial Systems SOMERSET OF ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der No.: 315002 Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:59 am Title XVIII Skilled Nursing PPS

Total Interim payments paid to provider					Facility		
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A	Par	t B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00							
Total interim payments paid to provider 7,530,653 0 1,00 2,00							
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero			1.00	2.00	3. 00	4. 00	
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero	1.00	Total interim payments paid to provider		7, 530, 653		0	1. 00
Services rendered in the cost reporting period. If none, enter zero.	2.00	Interim payments payable on individual bills, either		110, 845		0	2. 00
anount based on subsequent revision of the interin 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 3.02 3.03 3.04 3.05 3.06 3.06 3.07 3.07 3.08 3.09 3.09 3.09 3.00 3.01 3.00 3.01 3.00 3.01 3.01 3.02 3.03 3.04 3.05 3.06 3.06 3.07 3.08 3.09 3.09 3.09 3.09 3.09 3.09 3.00 3.01 3.01 3.01 3.01 3.02 3.03 3.04 3.05 3.06 3.06 3.07 3.08 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.00 3.00		submitted or to be submitted to the contractor for					
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		services rendered in the cost reporting period. If none,					
amount based on subsequent revision of the interin 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 3.02 3.03 3.04 3.05 Provider to Program 3.51 3.52 ADUSTMENTS TO PROVIDER 3.55 Provider to Program 3.51 3.52 ADUSTMENTS TO PROGRAM 3.55 ADUSTMENTS TO PROGRAM 3.56 ADUSTMENTS TO PROGRAM 3.57 ADUSTMENTS TO PROGRAM 3.58 ADUSTMENTS TO PROGRAM 3.59 ADUSTMENTS TO PROGRAM 3.50 ADUSTMENTS TO PROGRAM 3.51 3.52 ADUSTMENTS TO PROGRAM 3.55 ADUSTMENTS TO PROGRAM 3.56 ADUSTMENTS TO PROGRAM 3.57 ADUSTMENTS TO PROGRAM 3.58 ADUSTMENTS TO PROGRAM 3.59 ADUSTMENTS TO PROGRAM 3.50 ADUST		enter zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00	List separately each retroactive lump sum adjustment					3. 00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider		amount based on subsequent revision of the interim rate					
Program to Provider ADJUSTMENTS TO PROVIDER 0 0 3 .01		for the cost reporting period. Also show date of each					
Program to Provider ADJUSTMENTS TO PROVIDER 0 0 3 .01							
ADJUSTMENTS TO PROVIDER							Ī
3.02	3. 01			0		0	3. 01
3.04 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.51 3.52 3.53 3.54 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 2 for Part B) To BE COMPLETED BY CONTRACTOR 5.00 Froyram to Provider 5.01 5.50 Provider to Program TENTATI VE TO PROGRAM TENTATI				0			
3. 04 0 0 0 3. 04 3. 05						_	
3.05				-			
Provider to Program ADJUSTMENTS TO PROGRAM 06/15/2023 5,626 0 3.50 0 0 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 0 3.53 3.54 0 0 0 0 0 3.53 3.54 0 0 0 0 0 3.53 3.54 0 0 0 0 0 3.54 0 0 0 0 3.59 0 0 0 0 3.59 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
ADJUSTMENTS TO PROGRAM	3.05	Provider to Program		U		0	3.03
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 3.54 0 0 0 3.53 3.54 3.59 3.59 3.99	2 EO		04 /15 /2022	E 424			2 50
3.52 3.53 3.54 3.99 3.54 3.99 3.54 3.99 3.54 3.99 3.55 3.56 3.99 3.56 3.59		ADJUSTIMENTS TO PROGRAM	00/13/2023			_	
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 3.59 3.				U		_	
3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 -5,626 0 3.54 3.99 -3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 7,635,872 0 4.00 4				0		_	
3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 -5,626 0 3.99				0			
Contractor Name Contractor				0			
A	3. 99			-5, 626		0	3. 99
Citransfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR							
26 for Part B	4. 00			7, 635, 872		0	4. 00
TO BE COMPLETED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER							
5.02		Program to Provider					
Description	5.01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM	5.03			0		0	5. 03
TENTATI VE TO PROGRAM		Provider to Program					1
5.52 0 0 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0.01 PROGRAM TO PROVIDER 0 0 0 6.01 6.02 PROVIDER TO PROGRAM 53,119 0 6.02 7.00 Total Medicare program liability (see instructions) 7,582,753 0 7.00 Contractor Name Contractor Number 1.00 2.00	5.50			0		0	5.50
5.52 0 0 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0.01 PROGRAM TO PROVIDER 0 0 0 6.01 6.02 PROVIDER TO PROGRAM 53,119 0 6.02 7.00 Total Medicare program liability (see instructions) 7,582,753 0 7.00 Contractor Name Contractor Number 1.00 2.00	5. 51			0		0	5. 51
5. 99 Subtotal (Sum of lines 5. 01 - 5. 49 minus sum of lines 5. 50 0 0 5. 99 - 5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 0 0 0 0 0 0 0				0		0	
- 5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) - 5.98) 0 6.00 5.90 - 5.98) 0 7.00 - 6.00 - 7.582,753		Subtotal (Sum of lines 5 01 - 5 49 minus sum of lines 5 50		o o			
6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 PROGRAM TO PROVIDER 6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1. 00 2. 00	0. , ,			Ĭ			0. //
the cost report. (1) PROGRAM TO PROVIDER 6. 01 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor Name Contractor Name 1. 00 6. 01 6. 02 7. 582, 753 0 7. 00 Contractor Name 1. 00 2. 00	6 00						6.00
6. 01 PROGRAM TO PROVIDER 0 0 6. 01 6. 02 PROVIDER TO PROGRAM 53, 119 0 6. 02 7. 00 Total Medicare program liability (see instructions) 7, 582, 753 0 7. 00 Contractor Name Contractor Number 1. 00 2. 00	0.00						0.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) S3, 119	6.01					^	6.01
7.00 Total Medicare program Liability (see instructions) 7,582,753 Contractor Name Contractor Number 1.00 2.00				52 110		_	
Contractor Name Contractor Number		I					
Number 1.00 2.00	7.00	Tiotal medicale program frability (see instructions)		, ,			7.00
1.00 2.00				Contract	tor manne		
				4	00		
8.00 INAME OF CONTRACTOR I I 8.00	0.00	Name of Contractor		1.	UU	2.00	0.00
(1) On Lines 2 5 and 6, where an amount is due provider to program, show the amount and date on which the provider		·				l	J 8.00

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

Health Financial Systems

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

Provi der No.: 315002

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

onl y)			10 12/31/2023	5/10/2024 11:	
		General Fund	Specific Endowment Fund Purpose Fund		
		1.00	2.00 3.00	4. 00	
	Assets				-
1. 00	CURRENT ASSETS Cash on hand and in banks	13, 582		0	1.00
2. 00	Temporary investments	13, 362			
3. 00	Notes receivable	0		ol ö	
4. 00	Accounts receivable	1, 777, 328	ı "ı "ı	ol o	
5. 00	Other receivables	0	o o	o o	
6.00	Less: allowances for uncollectible notes and accounts	-255, 629	0	0	6.00
	recei vabl e				
7. 00	Inventory	0	0	0	
8.00	Prepaid expenses	14, 484	0	0	
9. 00 10. 00	Other current assets Due from other funds	249, 340		0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 799, 105			
11.00	FIXED ASSETS	1,777,103	<u> </u>	<u> </u>	11.00
12. 00	Land	1 0	0 0	0	12.00
13. 00	Land improvements	Ö	o o	1	
14.00	Less: Accumulated depreciation	0	0	0	14.00
15.00	Bui I di ngs	0	0	0	15. 00
16. 00	Less Accumulated depreciation	0	0 0	0	
17. 00	Leasehold improvements	0	0	0	
18.00	Less: Accumulated Amortization	0	0	0	
19.00	Fixed equipment	0	0	0	
20.00	Less: Accumulated depreciation	0		0	
21. 00 22. 00	Automobiles and trucks Less: Accumulated depreciation	0		0	
23. 00	Major movable equipment	0			
24. 00	Less: Accumulated depreciation	0		ol ö	
25. 00	Mi nor equipment - Depreciable	l o	ol o	ol o	
26.00	Mi nor equipment nondepreciable	0	o o	o o	
27.00	Other fixed assets	0	0	0	27. 00
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0	0 (0	28. 00
	OTHER ASSETS				
29. 00	Investments	0	· · · · · · · · · · · · · · · · · · ·	1	
30.00	Deposits on Leases	0	0	0	
31. 00 32. 00	Due from owners/officers Other assets	500	0 0	0	
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	500		1	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	1, 799, 605		ol ö	
	Liabilities and Fund Balances	, , , , , , , , , , , , , , , , , , , ,			
	CURRENT LI ABI LI TI ES				
35. 00	Accounts payable	822, 002		1	
36.00	Salaries, wages, and fees payable	692, 600		1	
37. 00	Payroll taxes payable	-26, 838		0	
38. 00 39. 00	Notes & Loans payable (Short term) Deferred income	0	0 0	0	
40. 00	Accel erated payments)	40.00
41. 00	Due to other funds	249, 340	0	o	
42. 00	Other current liabilities	-777, 669			
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	959, 435	0	0	43.00
	LONG TERM LIABILITIES				
44. 00	Mortgage payable	0	0 0		
45. 00	Notes payable	0	· · · · · · · · · · · · · · · · · · ·	0	
46.00	Unsecured Loans	0	0	0	
47. 00	Loans from owners:	11 70/ 020	0	0	
48. 00 49. 00	Other long term liabilities OTHER (SPECIFY)	11, 796, 829		0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	11, 796, 829	-		
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	12, 756, 264		1	
	CAPITAL ACCOUNTS	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1
52.00	General fund balance	-10, 956, 659			52.00
53.00	Specific purpose fund		0		53. 00
54.00	Donor created - endowment fund balance - restricted)	54.00
55.00	Donor created - endowment fund balance - unrestricted			2	55. 00
56.00	Governing body created - endowment fund balance)	56.00
57. 00 58. 00	Plant fund balance - invested in plant			0 0	
აი. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				58. 00
59. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-10, 956, 659		0	59. 00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	1, 799, 605		o o	
	59)]]	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315002

				1	0 12/31/2023	5/10/2024 11:	
		General	Fund	Special Pu	irpose Fund	Endowment Fund	37 diii
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	11.00	-9, 937, 992	0.00	0	0.00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-1, 018, 670				2. 00
3.00	Total (sum of line 1 and line 2)		-10, 956, 662		0		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00	ROUNDI NG	3		0		0	5. 00
6.00		0		0		0	6. 00
7.00		0		0		0	7. 00
8.00		0		0		0	8. 00
9.00		0		0		0	9. 00
10. 00	Total additions (sum of line 5 - 9)		3		0		10. 00
11. 00	Subtotal (line 3 plus line 10)		-10, 956, 659		0		11. 00
12. 00	Deductions (debit adjustments)						12.00
13. 00		0		0		0	13. 00
14.00		0		0		0	14. 00
15. 00		0		0		0	15. 00
16.00		0		0		0	16.00
17. 00	T	0		0		0	17. 00
18.00	Total deductions (sum of lines 13 - 17)		10.057.750		0		18.00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-10, 956, 659		0		19. 00
	Sheet (Line II - Iiie Io)	Endowment Fund	PI ant	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	ROUNDI NG		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8.00
9.00	T-+-1		U				9.00
10. 00 11. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0		0			10. 00 11. 00
11.00	(Subtotal (Time 3 plus line 10)	l UI					11.00
12 00		1					12 00
12.00	Deductions (debit adjustments)		0				12.00
13. 00			0				13. 00
13. 00 14. 00			0				13. 00 14. 00
13. 00 14. 00 15. 00			0 0				13. 00 14. 00 15. 00
13. 00 14. 00 15. 00 16. 00			0 0 0				13. 00 14. 00 15. 00 16. 00
13. 00 14. 00 15. 00 16. 00 17. 00	Deductions (debit adjustments)	O	0 0 0 0	n			13. 00 14. 00 15. 00 16. 00 17. 00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Deductions (debit adjustments) Total deductions (sum of lines 13 - 17)	0	0 0 0 0 0	0			13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
13. 00 14. 00 15. 00 16. 00 17. 00	Deductions (debit adjustments)		0 0 0 0 0				13. 00 14. 00 15. 00 16. 00 17. 00

Health Financial Systems	SOMERSET VALLEY REHAB A	ND NURSING CT	In Lie	u of Form CMS-2540-10

Heal th	Financial Systems SOMERSET VALLEY REHAB A	ND NURSING	CT	In Lie	eu of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023		pared: 59 am
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services		1	-1	1	
1.00	SKILLED NURSING FACILITY		9, 914, 63	1	9, 914, 631	1. 00
2.00	NURSING FACILITY			0	0	2.00
3.00	ICF/IID			0	0	3.00
4.00	OTHER LONG TERM CARE		0.014.60	0	0 044 (04	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		9, 914, 63	1	9, 914, 631	5. 00
4 00	ALL Other Care Services ANCILLARY SERVICES		8, 731, 83		8, 731, 830	/ 00
6. 00 7. 00	CLINIC		8, 731, 83	0		6. 00 7. 00
8.00	HOME HEALTH AGENCY COST				0	8.00
9. 00	AMBULANCE			0	0	9.00
10.00	RURAL HEALTH CLINIC				0	10.00
10. 00	FOHC				0	10. 00
11. 00	CMHC				0	11. 00
12. 00	HOSPI CE				0	12.00
13. 00	OTHER (SPECIFY)			0 0	_	13. 00
14. 00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	to	18, 646, 46	-	_	14. 00
00	Worksheet G-3, Line 1)		10,010,10		10,010,101	
	Cost Center Description		'			
	'			1. 00	2.00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				13, 461, 276	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	Tatal Baduatiana (Com af Linea 0 12)			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13) Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				0 13, 461, 276	14.00
15.00	Tiotal Operating Expenses (Sum of Times Fand 8, Minus Tine 14)				13, 401, 2/6	15.00

Health Financial Systems	SOMERSET VALLEY REHAB /	AND NURSING C	Τ	In Lie	eu of Form CMS-2540-10
OTATEMENT OF BATIENT BEVENUES AND	ODEDATI NO EVENIOSO		045000	Ta	Tu, 1 1 1 0 0

Heal th	Financial Systems SOMERSET VALLEY REHAM	B AND NURSING CT	In Lie	eu of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315002	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line			18, 646, 461	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	nts		6, 207, 785	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			12, 438, 676	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II,	line 15)		13, 461, 276	
5.00	Net income from service to patients (Line 3 minus 4)			-1, 022, 600	5. 00
	Other income:				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			1, 168	7. 00
8. 00	Revenues from communications (Telephone and Internet service	e)		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13. 00	Revenue from Laundry and Linen service			0	13. 00
	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	
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
	Rental of vending machines			0	
22. 00	Rental of skilled nursing space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	BARBER AND BEAUTY			86	24. 00
24. 01	OTHER REVENUE			1, 378	
24. 02	OTHER INCOME			1, 298	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)			3, 930	
26. 00	Total (Line 5 plus line 25)			-1, 018, 670	
27. 00	Other expenses (specify)			0	
28. 00				0	
29. 00				0	29. 00
	Total other expenses (Sum of lines 27 - 29)			0	
31. 00	Net income (or loss) for the period (Line 26 minus line 30)			-1, 018, 670	31.00