

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED  
OMB NO. 0938-0463  
Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/22/2024 10:42 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report <span style="float: right;">Date: 5/22/2024 Time: 10:42 am</span> 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WYNWOOD REHAB AND HEALTHCARE CTR ( 315047 ) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		Title XIX	
		Part A	Part B		
	1.00	2.00	3.00	4.00	
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00 SKILLED NURSING FACILITY	0	27,971	1,874	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	27,971	1,874	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/22/2024 10:42 am				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 1700 WYNWOOD DRIVE	PO Box:				1.00		
2.00	City: CINNAMINSON	State: NJ	Zip Code: 08077			2.00		
3.00	County: BURLINGTON	CBSA Code: 15804	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
					4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	WYNWOOD REHAB AND HEALTHCARE CTR	315047	01/01/1967	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00
				From:	To:			
				1.00	2.00			
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2023	12/31/2023		14.00	
15.00	Type of Control (See Instructions)				5LLC		15.00	
				Y/N				
				1.00				
<u>Type of Freestanding Skilled Nursing Facility</u>								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y		18.00
<u>Miscellaneous Cost Reporting Information</u>								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.01
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					487,031		20.00
21.00	Declining Balance					0		21.00
22.00	Sum of the Year's Digits					0		22.00
23.00	Sum of line 20 through 22					487,031		23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility					N		29.00
30.00	Nursing Facility					N		30.00
31.00	ICF/IID					N		31.00
32.00	SNF-Based HHA					N		32.00
33.00	SNF-Based RHC					N		33.00
34.00	SNF-Based FQHC					N		34.00
35.00	SNF-Based CMHC					N		35.00
36.00	SNF-Based OLTC					N		36.00
				Y/N				
				1.00			2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.							39.00
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:			0	0	0		41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/22/2024 10:42 am
				Y/N
				1.00
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N 42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			N 43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			44.00
	1.00	2.00	3.00	
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.				
45.00	Name:	Contractor's Name:	Contractor's Number:	45.00
46.00	Street:	PO Box:		46.00
47.00	City:	State:	Zip Code:	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/22/2024 10:42 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	03/13/2024	Y	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

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

Provider No. : 315047

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/22/2024 10:42 am

		1.00	2.00	
<b>Cost Report Preparer Contact Information</b>				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHRIS	GUI LBAULT	19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	CHRIS.GUI LBAULT@HCRNJ.NET	21.00

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

Provider No. : 315047

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/22/2024 10:42 am

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

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

Provider No. : 315047

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

Worksheet S-3  
 Part I  
 Date/Time Prepared:  
 5/22/2024 10:42 am

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	114	41,610	0	6,137	24,875	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	114	41,610	0	6,137	24,875	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	6,717	37,729	0	107	122	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	6,717	37,729	0	107	122	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	221	450	0.00	57.36	203.89	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	221	450	0.00	57.36	203.89	8.00
Component		Average Length of Stay		Admissions			
		Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
1.00	SKILLED NURSING FACILITY	83.84	0	162	111	166	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	83.84	0	162	111	166	8.00
Component		Admissions		Full Time Equivalent			
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	439	61.50	0.00		1.00	
2.00	NURSING FACILITY	0	0.00	0.00		2.00	
3.00	ICF/IID	0	0.00	0.00		3.00	
4.00	HOME HEALTH AGENCY COST					4.00	
5.00	Other Long Term Care	0	0.00	0.00		5.00	
6.00	SNF-Based CMHC					6.00	
7.00	HOSPICE	0	0.00	0.00		7.00	
8.00	Total (Sum of lines 1-7)	439	61.50	0.00		8.00	

Provider No. : 315047

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
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	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - DIRECT SALARIES</b>						
<b>SALARIES</b>						
1.00	Total salaries (See Instructions)	4,111,449	0	4,111,449	127,671.00	32.20
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	4,111,449	0	4,111,449	127,671.00	32.20
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST					
9.00	CMHC					
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	4,111,449	0	4,111,449	127,671.00	32.20
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	1,489,318	0	1,489,318	36,599.00	40.69
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	495,456	0	495,456		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	495,456	0	495,456		



SNF WAGE INDEX INFORMATION

Provider No. : 315047

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/22/2024 10:42 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - OVERHEAD COST - DIRECT SALARIES</b>						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	576,470	0	576,470	10,412.00	2.00
3.00	Plant Operation, Maintenance & Repairs	113,925	0	113,925	4,223.00	3.00
4.00	Laundry & Linen Service	2,532	0	2,532	154.00	4.00
5.00	Housekeeping	51,900	0	51,900	2,842.00	5.00
6.00	Dietary	0	0	0	0.00	6.00
7.00	Nursing Administration	536,574	0	536,574	11,271.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	93,596	0	93,596	2,186.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	122,996	0	122,996	6,151.00	13.00
14.00	Total (sum lines 1 thru 13)	1,497,993	0	1,497,993	37,239.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2024 10:42 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			4,489 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Qualified and Non-Qualified Pension Plan Cost			0 3.00
4.00	Prior Year Pension Service Cost			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			109,709 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			292 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			0 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	Workers' Compensation Insurance			28,342 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			303,488 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			42,905 19.00
20.00	State or Federal Unemployment Taxes			6,231 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)			495,456 24.00
				Amount Reported
				1.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315047

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/22/2024 10:42 am

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	378,574	51,675	430,249	8,096.00	53.14	1.00
2.00	Licensed Practical Nurses (LPNs)	1,192,481	162,774	1,355,255	32,286.00	41.98	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,042,402	142,288	1,184,690	50,051.00	23.67	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,613,457	356,737	2,970,194	90,433.00	32.84	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
<b>Contract Labor</b>							
<b>Nursing Occupations</b>							
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	324,247		324,247	6,539.00	49.59	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	500,332		500,332	16,280.00	30.73	16.00
17.00	Total Nursing (sum of lines 14 through 16)	824,579		824,579	22,819.00	36.14	17.00
18.00	Physical Therapists	270,593		270,593	5,561.00	48.66	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	269,140		269,140	5,453.00	49.36	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	125,005		125,005	2,765.00	45.21	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315047

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

Worksheet S-7

Date/Time Prepared:  
5/22/2024 10:42 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315047

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

Worksheet S-7

Date/Time Prepared:  
5/22/2024 10:42 am

		Group	Days	
76.00		1.00	2.00	
99.00		PA1		76.00
100.00	TOTAL	AAA		99.00
				100.00
		Expenses	Percentage	Y/N
		1.00	2.00	3.00
<p>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)</p>				
101.00	Staffing			101.00
102.00	Recruitment			102.00
103.00	Retention of employees			103.00
104.00	Training			104.00
105.00	OTHER (SPECIFY)			105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)			106.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider No. : 315047		Period: From 01/01/2023 To 12/31/2023		Worksheet A	
Date/Time Prepared: 5/22/2024 10:42 am								
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		2,780,985	2,780,985	0	2,780,985	1.00
3.00	00300	EMPLOYEE BENEFITS	0	561,277	561,277	0	561,277	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	576,470	2,486,038	3,062,508	0	3,062,508	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	113,925	438,403	552,328	0	552,328	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	2,532	115,502	118,034	0	118,034	6.00
7.00	00700	HOUSEKEEPING	51,900	379,737	431,637	0	431,637	7.00
8.00	00800	DIETARY	0	984,080	984,080	0	984,080	8.00
9.00	00900	NURSING ADMINISTRATION	536,574	59,806	596,380	0	596,380	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	142,263	142,263	0	142,263	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	93,596	2,100	95,696	0	95,696	13.00
15.00	01500	PATIENT ACTIVITIES	122,996	23,929	146,925	0	146,925	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	2,613,456	860,579	3,474,035	0	3,474,035	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	12,609	12,609	0	12,609	40.00
41.00	04100	LABORATORY	0	15,328	15,328	0	15,328	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	28,221	28,221	0	28,221	43.00
44.00	04400	PHYSICAL THERAPY	0	296,980	296,980	0	296,980	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	268,097	268,097	0	268,097	45.00
46.00	04600	SPEECH PATHOLOGY	0	125,701	125,701	0	125,701	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	349,593	349,593	0	349,593	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	59,360	59,360	0	59,360	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE		0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	4,111,449	9,990,588	14,102,037	0	14,102,037	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
100.00		TOTAL	4,111,449	9,990,588	14,102,037	0	14,102,037	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/22/2024 10:42 am
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Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-285,576	2,495,409	1.00
3.00	00300	EMPLOYEE BENEFITS	0	561,277	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-770,578	2,291,930	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	552,328	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	118,034	6.00
7.00	00700	HOUSEKEEPING	0	431,637	7.00
8.00	00800	DIETARY	0	984,080	8.00
9.00	00900	NURSING ADMINISTRATION	0	596,380	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	142,263	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	95,696	13.00
15.00	01500	PATIENT ACTIVITIES	0	146,925	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	0	3,474,035	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	0	12,609	40.00
41.00	04100	LABORATORY	0	15,328	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	28,221	43.00
44.00	04400	PHYSICAL THERAPY	0	296,980	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	268,097	45.00
46.00	04600	SPEECH PATHOLOGY	0	125,701	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	349,593	49.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
71.00	07100	AMBULANCE	0	59,360	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	-1,056,154	13,045,883	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
100.00		TOTAL	-1,056,154	13,045,883	100.00

Provider No. : 315047

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

Worksheet A-6  
Date/Time Prepared:  
5/22/2024 10:42 am

		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)				0	0 100.00

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



Provider No. : 315047

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

Worksheet A-6  
Date/Time Prepared:  
5/22/2024 10:42 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315047

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

Worksheet A-7

Date/Time Prepared:  
5/22/2024 10:42 am

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00 Land	0	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	0	0	0	0	0	3.00
4.00 Building Improvements	1,224,499	233,626	0	233,626	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	257,000	29,693	0	29,693	0	6.00
7.00 Subtotal (sum of lines 1-6)	1,481,499	263,319	0	263,319	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	1,481,499	263,319	0	263,319	0	9.00
<b>ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
<b>ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00 Land	0	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	0	0				
4.00 Building Improvements	1,458,125	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	286,693	0				
7.00 Subtotal (sum of lines 1-6)	1,744,818	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	1,744,818	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315047

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

Worksheet A-8

Date/Time Prepared:  
5/22/2024 10:42 am

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line No.
			1.00	2.00	3.00
1.00 Investment income on restricted funds (chapter 2)	B	-2,967	CAP REL COSTS - BLDGS & FIXTURES		1.00 1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 2.00
3.00 Refunds and rebates of expenses (chapter 8)		0			0.00 3.00
4.00 Rental of provider space by suppliers (chapter 8)		0			0.00 4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 5.00
6.00 Television and radio service (chapter 21)		0			0.00 6.00
7.00 Parking lot (chapter 21)		0			0.00 7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00 Home office cost (chapter 21)		0			0.00 9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00 11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-440,362			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Revenue - Employee meals		0			0.00 14.00
15.00 Cost of meals - Guests		0			0.00 15.00
16.00 Sale of medical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts	B	-12	ADMINISTRATIVE & GENERAL		4.00 18.00
19.00 Vending machines		0			0.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00 22.00
23.00 Depreciation--buildings and fixtures			CAP REL COSTS - BLDGS & FIXTURES		1.00 23.00
24.00 Depreciation--movable equipment		0	*** Cost Center Deleted ***		2.00 24.00
25.00 Other adjustment (specify)		0			0.00 25.00
25.01 OTHER REV-CREDIT CARD CASH BACK	B	-549	ADMINISTRATIVE & GENERAL		4.00 25.01
25.02 RESIDENT MISSING ITEMS	A	-1,170	ADMINISTRATIVE & GENERAL		4.00 25.02
25.03 CORPORATE TAX	A	-233,905	ADMINISTRATIVE & GENERAL		4.00 25.03
25.04 FINES & PENALTIES	A	-115	ADMINISTRATIVE & GENERAL		4.00 25.04
25.05 DONATIONS/CHARITY	A	-1,000	ADMINISTRATIVE & GENERAL		4.00 25.05
25.06 BAD DEBT	A	-301,800	ADMINISTRATIVE & GENERAL		4.00 25.06
25.07 OTHER REV - TRANSPORTATION	A	-772	ADMINISTRATIVE & GENERAL		4.00 25.07
25.08 MARKETING	A	-73,502	ADMINISTRATIVE & GENERAL		4.00 25.08
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,056,154			100.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

Provider No. : 315047

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

Worksheet A-8-1  
Parts I-II  
Date/Time Prepared:  
5/22/2024 10:42 am

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00	
2.00	4.00	ADMINISTRATIVE & GENERAL	REALTY ADMIN COSTS	2.00	
3.00	4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT	3.00	
4.00	0.00			4.00	
5.00	0.00			5.00	
6.00	0.00			6.00	
7.00	0.00			7.00	
8.00	0.00			8.00	
9.00	0.00			9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00	
		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
		4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2,117,391	2,400,000	-282,609	1.00	
2.00	3,218	0	3,218	2.00	
3.00	515,771	676,742	-160,971	3.00	
4.00	0	0	0	4.00	
5.00	0	0	0	5.00	
6.00	0	0	0	6.00	
7.00	0	0	0	7.00	
8.00	0	0	0	8.00	
9.00	0	0	0	9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00	
	2,636,380	3,076,742	-440,362		

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/22/2024 10:42 am
	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

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

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

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

1.00	A	PINCHOS BAK	30.00	1.00
2.00	A	SHLOMO GOLDBERGER	30.00	2.00
3.00	A	DAVID HERZKA	15.00	3.00
4.00	A	MOSHE SONNENSCHINE	25.00	4.00
5.00	A	PINCHOS BAK	30.00	5.00
6.00	A	SHLOMO GOLDBERGER	30.00	6.00
7.00	A	MOSHE SONNENSCHINE	25.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00		SPECTRUM PROPCO REALTY LLC	30.00	1.00
2.00		SPECTRUM PROPCO REALTY LLC	30.00	2.00
3.00		SPECTRUM PROPCO REALTY LLC	15.00	3.00
4.00		SPECTRUM PROPCO REALTY LLC	25.00	4.00
5.00		ATLAS HEALTHCARE MANAGEMENT	33.30	5.00
6.00		ATLAS HEALTHCARE MANAGEMENT	33.30	6.00
7.00		ATLAS HEALTHCARE MANAGEMENT	33.30	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315047

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	2,495,409	2,495,409			1.00
3.00 00300	EMPLOYEE BENEFITS	561,277	58,718	619,995		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,291,930	378,092	86,930	2,756,952	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	552,328	134,075	17,180	703,583	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	118,034	137,037	382	255,453	6.00
7.00 00700	HOUSEKEEPING	431,637	37,025	7,826	476,488	7.00
8.00 00800	DIETARY	984,080	244,627	0	1,228,707	8.00
9.00 00900	NURSING ADMINISTRATION	596,380	24,742	80,914	702,036	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	142,263	0	0	142,263	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	95,696	6,969	14,114	116,779	13.00
15.00 01500	PATIENT ACTIVITIES	146,925	0	18,547	165,472	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	3,474,035	1,331,076	394,102	5,199,213	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	12,609	0	0	12,609	40.00
41.00 04100	LABORATORY	15,328	0	0	15,328	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	28,221	0	0	28,221	43.00
44.00 04400	PHYSICAL THERAPY	296,980	74,922	0	371,902	44.00
45.00 04500	OCCUPATIONAL THERAPY	268,097	52,009	0	320,106	45.00
46.00 04600	SPEECH PATHOLOGY	125,701	0	0	125,701	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	349,593	16,117	0	365,710	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	59,360	0	0	59,360	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	13,045,883	2,495,409	619,995	13,045,883	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	13,045,883	2,495,409	619,995	13,045,883	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315047

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	892,110				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	63,523	387,425			6.00
7.00	00700	HOUSEKEEPING	17,163	0	621,327		7.00
8.00	00800	DIETARY	113,397	0	86,831	1,758,171	8.00
9.00	00900	NURSING ADMINISTRATION	11,469	0	8,782	0	910,400
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
13.00	01300	SOCIAL SERVICE	3,231	0	2,474	0	0
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	617,017	387,425	472,465	1,758,171	910,400
31.00	03100	NURSING FACILITY	0	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	RADIOLOGY	0	0	0	0	0
41.00	04100	LABORATORY	0	0	0	0	0
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00	04400	PHYSICAL THERAPY	34,730	0	26,593	0	0
45.00	04500	OCCUPATIONAL THERAPY	24,109	0	18,461	0	0
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	7,471	0	5,721	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	AMBULANCE	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	892,110	387,425	621,327	1,758,171	910,400
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0
98.00		Cross Foot Adjustments	0	0	0	0	0
99.00		Negative Cost Centers	0	0	0	0	0
100.00		TOTAL	892,110	387,425	621,327	1,758,171	910,400

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315047

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
	10.00	12.00	13.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	180,383				10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0			12.00
13.00 01300	SOCIAL SERVICE	0	0	153,775		13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	209,811	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	52,173	0	153,775	209,811	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	128,210	0	0	0	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	180,383	0	153,775	209,811	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	180,383	0	153,775	209,811	100.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315047

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description		Post Stepdown Adjustments	Total	
		17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	SKILLED NURSING FACILITY	0 11,153,597	30.00
31.00	03100	NURSING FACILITY	0 0	31.00
32.00	03200	ICF/IID	0 0	32.00
33.00	03300	OTHER LONG TERM CARE	0 0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00	04000	RADIOLOGY	0 15,988	40.00
41.00	04100	LABORATORY	0 19,435	41.00
42.00	04200	INTRAVENOUS THERAPY	0 0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0 35,783	43.00
44.00	04400	PHYSICAL THERAPY	0 532,877	44.00
45.00	04500	OCCUPATIONAL THERAPY	0 448,449	45.00
46.00	04600	SPEECH PATHOLOGY	0 159,383	46.00
47.00	04700	ELECTROCARDIOLOGY	0 0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0 605,105	49.00
51.00	05100	SUPPORT SURFACES	0 0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00	07100	AMBULANCE	0 75,266	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0 0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	0 13,045,883	89.00
<b>NONREIMBURSABLE COST CENTERS</b>				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0 0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0 0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0 0	92.00
93.00	09300	NONPAID WORKERS	0 0	93.00
94.00	09400	PATIENTS LAUNDRY	0 0	94.00
98.00		Cross Foot Adjustments	0 0	98.00
99.00		Negative Cost Centers	0 0	99.00
100.00		TOTAL	0 13,045,883	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315047

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		0	BLDGS & FIXTURES				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
3.00	00300	0	58,718	58,718	58,718		3.00
4.00	00400	0	378,092	378,092	8,233	386,325	4.00
5.00	00500	0	134,075	134,075	1,627	26,418	5.00
6.00	00600	0	137,037	137,037	36	9,592	6.00
7.00	00700	0	37,025	37,025	741	17,891	7.00
8.00	00800	0	244,627	244,627	0	46,135	8.00
9.00	00900	0	24,742	24,742	7,663	26,360	9.00
10.00	01000	0	0	0	0	5,342	10.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	6,969	6,969	1,337	4,385	13.00
15.00	01500	0	0	0	1,757	6,213	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	1,331,076	1,331,076	37,324	195,216	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	473	40.00
41.00	04100	0	0	0	0	576	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	1,060	43.00
44.00	04400	0	74,922	74,922	0	13,964	44.00
45.00	04500	0	52,009	52,009	0	12,019	45.00
46.00	04600	0	0	0	0	4,720	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	16,117	16,117	0	13,732	49.00
51.00	05100	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	0	0	0	0	2,229	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	2,495,409	2,495,409	58,718	386,325	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
100.00		0	2,495,409	2,495,409	58,718	386,325	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315047

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	162,120				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	11,544	158,209			6.00
7.00	00700	HOUSEKEEPING	3,119	0	58,776		7.00
8.00	00800	DIETARY	20,607	0	8,214	319,583	8.00
9.00	00900	NURSING ADMINISTRATION	2,084	0	831	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	587	0	234	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	112,129	158,209	44,694	319,583	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	6,311	0	2,516	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	4,381	0	1,746	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	1,358	0	541	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	AMBULANCE	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	162,120	158,209	58,776	319,583	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	99.00
100.00		TOTAL	162,120	158,209	58,776	319,583	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315047

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
	10.00	12.00	13.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	5,342				10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0			12.00
13.00 01300	SOCIAL SERVICE	0	0	13,512		13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	7,970	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	1,545	0	13,512	7,970	2,282,938 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	0	473 40.00
41.00 04100	LABORATORY	0	0	0	0	576 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	1,060 43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	97,713 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	70,155 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	4,720 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	3,797	0	0	0	35,545 49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	0	2,229 71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	5,342	0	13,512	7,970	2,495,409 89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	5,342	0	13,512	7,970	2,495,409 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315047

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description		Post Step-Down Adjustments	Total	
		17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	SKILLED NURSING FACILITY	0	2,282,938
31.00	03100	NURSING FACILITY	0	0
32.00	03200	ICF/IID	0	0
33.00	03300	OTHER LONG TERM CARE	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00	04000	RADIOLOGY	0	473
41.00	04100	LABORATORY	0	576
42.00	04200	INTRAVENOUS THERAPY	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	1,060
44.00	04400	PHYSICAL THERAPY	0	97,713
45.00	04500	OCCUPATIONAL THERAPY	0	70,155
46.00	04600	SPEECH PATHOLOGY	0	4,720
47.00	04700	ELECTROCARDIOLOGY	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0	35,545
51.00	05100	SUPPORT SURFACES	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00	07100	AMBULANCE	0	2,229
<b>SPECIAL PURPOSE COST CENTERS</b>				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	0
89.00		SUBTOTALS (sum of lines 1-84)	0	2,495,409
<b>NONREIMBURSABLE COST CENTERS</b>				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0
91.00	09100	BARBER AND BEAUTY SHOP	0	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0
93.00	09300	NONPAID WORKERS	0	0
94.00	09400	PATIENTS LAUNDRY	0	0
98.00		Cross Foot Adjustments	0	0
99.00		Negative Cost Centers	0	0
100.00		TOTAL	0	2,495,409

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315047

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

Worksheet B-1  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	BLDGS & FIXTURES (SQUARE FEET)					
	1.00	3.00	4A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	28,644				1.00
3.00 00300	EMPLOYEE BENEFITS	674	4,111,449			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	4,340	576,470	-2,756,952	10,288,931	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,539	113,925	0	703,583	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,573	2,532	0	255,453	6.00
7.00 00700	HOUSEKEEPING	425	51,900	0	476,488	7.00
8.00 00800	DIETARY	2,808	0	0	1,228,707	8.00
9.00 00900	NURSING ADMINISTRATION	284	536,574	0	702,036	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	142,263	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	80	93,596	0	116,779	13.00
15.00 01500	PATIENT ACTIVITIES	0	122,996	0	165,472	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	15,279	2,613,456	0	5,199,213	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	12,609	40.00
41.00 04100	LABORATORY	0	0	0	15,328	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	28,221	43.00
44.00 04400	PHYSICAL THERAPY	860	0	0	371,902	44.00
45.00 04500	OCCUPATIONAL THERAPY	597	0	0	320,106	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	125,701	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	185	0	0	365,710	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	59,360	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	28,644	4,111,449	-2,756,952	10,288,931	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2,495,409	619,995		2,756,952	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	87.118035	0.150797		0.267953	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		58,718		386,325	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.014282		0.037548	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315047

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

Worksheet B-1  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)		
		6.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
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	37,729				6.00	
7.00	00700	HOUSEKEEPING	0	20,093			7.00	
8.00	00800	DIETARY	0	2,808	113,187		8.00	
9.00	00900	NURSING ADMINISTRATION	0	284	0	113,252	9.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	491,856	10.00	
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00	
13.00	01300	SOCIAL SERVICE	0	80	0	0	13.00	
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	37,729	15,279	113,187	113,252	142,263	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	860	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	597	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	185	0	0	349,593	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	37,729	20,093	113,187	113,252	491,856	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	387,425	621,327	1,758,171	910,400	180,383	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	10.268626	30.922560	15.533330	8.038710	0.366739	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	158,209	58,776	319,583	61,680	5,342	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	4.193300	2.925198	2.823496	0.544626	0.010861	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315047

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

Worksheet B-1

Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT DAYS)	
	12.00	13.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
3.00 00300 EMPLOYEE BENEFITS				3.00
4.00 00400 ADMINISTRATIVE & GENERAL				4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 00600 LAUNDRY & LINEN SERVICE				6.00
7.00 00700 HOUSEKEEPING				7.00
8.00 00800 DIETARY				8.00
9.00 00900 NURSING ADMINISTRATION				9.00
10.00 01000 CENTRAL SERVICES & SUPPLY				10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	37,729			12.00
13.00 01300 SOCIAL SERVICE	0	37,729		13.00
15.00 01500 PATIENT ACTIVITIES	0	0	37,729	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000 SKILLED NURSING FACILITY	37,729	37,729	37,729	30.00
31.00 03100 NURSING FACILITY	0	0	0	31.00
32.00 03200 ICF/IID	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00 04000 RADIOLOGY	0	0	0	40.00
41.00 04100 LABORATORY	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	46.00
47.00 04700 ELECTROCARDIOLOGY	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00 07100 AMBULANCE	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00 08100 INTEREST EXPENSE				81.00
82.00 08200 UTILIZATION REVIEW - SNF				82.00
83.00 08300 HOSPICE	0	0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	37,729	37,729	37,729	89.00
<b>NONREIMBURSABLE COST CENTERS</b>				
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	94.00
98.00 Cross Foot Adjustments				98.00
99.00 Negative Cost Centers				99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	0	153,775	209,811	102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	4.075777	5.561001	103.00
104.00 Cost to be allocated (per Wkst. B, Part II)	0	13,512	7,970	104.00
105.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.358133	0.211243	105.00



RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/22/2024 10:42 am	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	15,988	0	0.000000 40.00
41.00	04100	LABORATORY	19,435	0	0.000000 41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	35,783	0	0.000000 43.00
44.00	04400	PHYSICAL THERAPY	532,877	465,766	1.144087 44.00
45.00	04500	OCCUPATIONAL THERAPY	448,449	432,810	1.036134 45.00
46.00	04600	SPEECH PATHOLOGY	159,383	284,508	0.560206 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000 47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	605,105	138,489	4.369336 49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000 51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	07100	AMBULANCE	75,266	0	0.000000 71.00
100.00		Total	1,892,286	1,321,573	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Provider No. : 315047

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/22/2024 10:42 am

Title XVIII (1)

Skilled Nursing  
Facility

PPS

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
			1.00	2.00	3.00	4.00		5.00
<b>PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST</b>								
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0.000000	0	0	0	0	40.00
41.00	04100	LABORATORY	0.000000	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1.144087	261,391	0	299,054	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	1.036134	218,506	0	226,401	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.560206	121,552	0	68,094	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	4.369336	124,528	0	544,105	0	49.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		725,977	0	1,137,654	0	100.00

(1) For title V and XIX use columns 1, 2, and 4 only.

(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/22/2024 10:42 am
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST					
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		4.369336	1.00
2.00		Program vaccine charges (From your records, or the PS&R)		5,310	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		23,201	3.00

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

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	15,988	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	19,435	0	0.000000	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	35,783	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	532,877	0	0.000000	299,054	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	448,449	0	0.000000	226,401	0	45.00
46.00	04600	SPEECH PATHOLOGY	159,383	0	0.000000	68,094	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	605,105	0	0.000000	544,105	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	1,817,020	0		1,137,654	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/22/2024 10:42 am
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
<b>PART I CALCULATION OF INPATIENT ROUTINE COSTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days including private room days		37,729	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		6,137	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		11,153,597	5.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
6.00	General inpatient routine service charges		13,408,018	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.831860	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		11,153,597	15.00
<b>PROGRAM INPATIENT ROUTINE SERVICE COSTS</b>				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		295.62	16.00
17.00	Program routine service cost (Line 3 times line 16)		1,814,220	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		1,814,220	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		2,282,938	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		60.51	21.00
22.00	Program capital related cost (Line 3 times line 21)		371,350	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		1,442,870	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		1,442,870	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

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

			1.00	
<b>PART II CALCULATION OF INPATIENT NURSING &amp; ALLIED HEALTH COSTS FOR PPS PASS-THROUGH</b>				
1.00	Total SNF inpatient days		37,729	1.00
2.00	Program inpatient days (see instructions)		6,137	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)		0.162660	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/22/2024 10:42 am
		Title XVIII	Skilled Nursing Facility	PPS

			1.00	
<b>PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT</b>				
1.00	Inpatient PPS amount (See Instructions)		4,183,440	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		4,183,440	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		878,800	5.00
6.00	Allowable bad debts (From your records)		733,019	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		480,935	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		476,462	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)		3,781,102	11.00
12.00	Interim payments (See instructions)		3,677,509	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		9,529	14.75
14.99	Sequestration amount (see instructions)		66,093	14.99
15.00	Balance due provider/program (see Instructions)		27,971	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
<b>PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY</b>				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		23,201	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		23,201	19.00
20.00	Medicare Part B ancillary charges (See instructions)		5,310	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		5,310	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		5,310	25.00
26.00	Interim payments (See instructions)		3,330	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		106	28.99
29.00	Balance due provider/program (see instructions)		1,874	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315047	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/22/2024 10:42 am	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		3,698,126		3,330
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/20/2023	20,617		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		-20,617		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		3,677,509		3,330
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	PROGRAM TO PROVIDER		27,971		1,874
6.02	PROVIDER TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		3,705,480		5,204
			Contractor Name		Contractor Number
			1.00	2.00	
8.00	Name of Contractor				

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

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

Provider No. : 315047

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

Worksheet G

Date/Time Prepared:  
5/22/2024 10:42 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>Assets</b>						
<b>CURRENT ASSETS</b>						
1.00	Cash on hand and in banks	1,373,373	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,355,223	0	0	0	4.00
5.00	Other receivables	62,881	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-44,761	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	93,913	0	0	0	8.00
9.00	Other current assets	32,180	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	<b>TOTAL CURRENT ASSETS (Sum of lines 1 - 10)</b>	<b>3,872,809</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,458,125	0	0	0	17.00
18.00	Less: Accumulated Amortization	-211,038	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	286,693	0	0	0	23.00
24.00	Less: Accumulated depreciation	-166,468	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	<b>TOTAL FIXED ASSETS (Sum of lines 12 - 27)</b>	<b>1,367,312</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28.00</b>
<b>OTHER ASSETS</b>						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	35,759	0	0	0	30.00
31.00	Due from owners/officers	69,760	0	0	0	31.00
32.00	Other assets	129,977	0	0	0	32.00
33.00	<b>TOTAL OTHER ASSETS (Sum of lines 29 - 32)</b>	<b>235,496</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33.00</b>
34.00	<b>TOTAL ASSETS (Sum of lines 11, 28, and 33)</b>	<b>5,475,617</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34.00</b>
<b>Liabilities and Fund Balances</b>						
<b>CURRENT LIABILITIES</b>						
35.00	Accounts payable	875,076	0	0	0	35.00
36.00	Salaries, wages, and fees payable	221,949	0	0	0	36.00
37.00	Payroll taxes payable	9,499	0	0	0	37.00
38.00	Notes & loans payable (Short term)	113,083	0	0	0	38.00
39.00	Deferred income	532,740	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	8,049	0	0	0	42.00
43.00	<b>TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)</b>	<b>1,760,396</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43.00</b>
<b>LONG TERM LIABILITIES</b>						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	<b>TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>TOTAL LIABILITIES (Sum of lines 43 and 50)</b>	<b>1,760,396</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	3,715,221	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	<b>TOTAL FUND BALANCES (Sum of lines 52 thru 58)</b>	<b>3,715,221</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>59.00</b>
60.00	<b>TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)</b>	<b>5,475,617</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315047

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

Worksheet G-1

Date/Time Prepared:  
5/22/2024 10:42 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		5,421,247		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-506,026			2.00
3.00	Total (sum of line 1 and line 2)		4,915,221		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		4,915,221		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00	RETURN OF CAPITAL	1,200,000		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		1,200,000		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		3,715,221		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)					4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 5 - 9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)					12.00
13.00	RETURN OF CAPITAL		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0		19.00



STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315047

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

Worksheet G-2  
Parts I-III  
Date/Time Prepared:  
5/22/2024 10:42 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	13,408,018		13,408,018	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	13,408,018		13,408,018	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,321,573	0	1,321,573	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD	53,530	0	53,530	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	14,783,121	0	14,783,121	14.00
Cost Center Description			1.00	2.00	
<b>PART II - OPERATING EXPENSES</b>					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			14,102,037	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			14,102,037	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315047

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

Worksheet G-3

Date/Time Prepared:  
5/22/2024 10:42 am

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	14,783,121	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,186,698	2.00
3.00	Net patient revenues (Line 1 minus line 2)	13,596,423	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	14,102,037	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-505,614	5.00
<b>Other income:</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,967	7.00
8.00	Revenues from communications ( Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	12	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PRIOR YEAR	-4,712	24.00
24.01	NON PATIENT REVENUE	1,321	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	-412	25.00
26.00	Total (Line 5 plus line 25)	-506,026	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-506,026	31.00