

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: 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/28/2024 12:55 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOMESTEAD REHAB AND HEALTHCARE CTR. ( 315378 ) 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		2	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00 SKILLED NURSING FACILITY	0	44,542	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	44,542	0	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 12:55 pm					
1.00		2.00		3.00					
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:									
1.00	Street: 129 MORRIS TURNPIKE	PO Box:				1.00			
2.00	City: NEWTON	State: NJ	Zip Code: 07860			2.00			
3.00	County: SUSSEX	CBSA Code: 35084	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	HOMESTEAD REHAB AND HEALTHCARE CTR.	315378	12/01/1997	N	P	N	4.00	
5.00	Nursing Facility							5.00	
6.00	ICF/IID							6.00	
7.00	SNF-Based HHA							7.00	
8.00	SNF-Based RHC							8.00	
9.00	SNF-Based FQHC							9.00	
10.00	SNF-Based CMHC							10.00	
11.00	SNF-Based OLTC							11.00	
12.00	SNF-Based HOSPICE							12.00	
13.00	SNF-Based CORF							13.00	
				From:	To:				
				1.00	2.00				
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2023	12/31/2023		14.00		
15.00	Type of Control (See Instructions)				4		15.00		
				Y/N					
				1.00					
Type of Freestanding Skilled Nursing Facility									
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					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	
Miscellaneous Cost Reporting Information									
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.									
20.00	Straight Line					514,261		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					514,261		23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00	
				Part A	Part B	Other			
				1.00	2.00	3.00			
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.									
29.00	Skilled Nursing Facility					N	N	N	29.00
30.00	Nursing Facility								30.00
31.00	ICF/IID								31.00
32.00	SNF-Based HHA					N	N		32.00
33.00	SNF-Based RHC								33.00
34.00	SNF-Based FQHC								34.00
35.00	SNF-Based CMHC						N		35.00
36.00	SNF-Based OLTC								36.00
				Y/N					
				1.00			2.00		
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y			37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					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. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 12:55 pm
				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. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 12:55 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)		N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.		N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.		N		8.00
			Y/N		
			1.00		
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
			Part A		Part B
			Description	Date	Y/N
			0	1.00	2.00
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.)		N		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		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		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		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		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		Y		18.00

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

Provider No. : 315378

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/28/2024 12:55 pm

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

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

Provider No. : 315378

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/28/2024 12:55 pm

		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.)		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. : 315378

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

Worksheet S-3  
 Part I  
 Date/Time Prepared:  
 5/28/2024 12:55 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	128	46,720	0	4,711	14,031	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	128	46,720	0	4,711	14,031	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	5,088	23,830	0	136	15	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	5,088	23,830	0	136	15	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	78	229	0.00	34.64	935.40	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	78	229	0.00	34.64	935.40	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	104.06	0	155	10	59	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	104.06	0	155	10	59	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	224	92.00	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	224	92.00	0.00	8.00		

Provider No. : 315378

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2024 12:55 pm

	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)	4,999,146	0	4,999,146	191,226.00	26.14 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	4,999,146	0	4,999,146	191,226.00	26.14 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	4,999,146	0	4,999,146	191,226.00	26.14 13.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	984,851	0	984,851	19,901.00	49.49 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	1,039,423	0	1,039,423		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	1,039,423	0	1,039,423		



SNF WAGE INDEX INFORMATION

Provider No. : 315378

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/28/2024 12:55 pm

	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	922,073	0	922,073	22,240.00	2.00
3.00	Plant Operation, Maintenance & Repairs	88,012	0	88,012	3,958.00	3.00
4.00	Laundry & Linen Service	31,557	0	31,557	2,195.00	4.00
5.00	Housekeeping	230,680	0	230,680	14,048.00	5.00
6.00	Dietary	605,958	0	605,958	29,138.00	6.00
7.00	Nursing Administration	184,805	0	184,805	7,445.00	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	62,324	0	62,324	2,080.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	209,276	0	209,276	12,782.00	13.00
14.00	Total (sum lines 1 thru 13)	2,334,685	0	2,334,685	93,886.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2024 12:55 pm
				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		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
<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)		317,902	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		290,605	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		368,000	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		62,916	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)		1,039,423	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. : 315378

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/28/2024 12:55 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	290,860	60,557	351,417	5,323.00	66.02	1.00
2.00	Licensed Practical Nurses (LPNs)	771,536	160,634	932,170	27,346.00	34.09	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,143,265	238,028	1,381,293	52,111.00	26.51	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,205,661	459,219	2,664,880	84,780.00	31.43	4.00
5.00	Physical Therapists	114,837	23,909	138,746	2,826.00	49.10	5.00
6.00	Physical Therapy Assistants	155,269	32,327	187,596	3,821.00	49.10	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	151,206	31,481	182,687	3,721.00	49.10	8.00
9.00	Occupational Therapy Assistants	64,123	13,350	77,473	1,578.00	49.10	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	24,950	5,195	30,145	614.00	49.10	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)	163,458		163,458	2,881.00	56.74	14.00
15.00	Licensed Practical Nurses (LPNs)	271,669		271,669	5,989.00	45.36	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	39,338		39,338	1,348.00	29.18	16.00
17.00	Total Nursing (sum of lines 14 through 16)	474,465		474,465	10,218.00	46.43	17.00
18.00	Physical Therapists	218,580		218,580	3,769.00	57.99	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	248,057		248,057	4,352.00	57.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	43,749		43,749	1,562.00	28.01	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. : 315378

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

Worksheet S-7

Date/Time Prepared:  
5/28/2024 12:55 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315378

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

Worksheet S-7

Date/Time Prepared:  
5/28/2024 12:55 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315378

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

Worksheet A  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1,727,375	1,727,375	0	1,727,375	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		0	0	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	1,040,893	1,040,893	0	1,040,893	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	922,073	893,599	1,815,672	0	1,815,672	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	88,012	219,455	307,467	0	307,467	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	31,557	10,203	41,760	0	41,760	6.00
7.00	00700	HOUSEKEEPING	230,680	17,167	247,847	0	247,847	7.00
8.00	00800	DIETARY	605,958	287,317	893,275	0	893,275	8.00
9.00	00900	NURSING ADMINISTRATION	184,805	0	184,805	0	184,805	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	121,633	121,633	0	121,633	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	51,941	51,941	0	51,941	12.00
13.00	01300	SOCIAL SERVICE	62,324	0	62,324	0	62,324	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	209,276	28,774	238,050	0	238,050	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	2,154,075	557,373	2,711,448	0	2,711,448	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	18,407	18,407	0	18,407	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	218,580	90	218,670	0	218,670	44.00
45.00	04500	OCCUPATIONAL THERAPY	248,057	29	248,086	0	248,086	45.00
46.00	04600	SPEECH PATHOLOGY	43,749	0	43,749	0	43,749	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	142,660	142,660	0	142,660	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	46,396	46,396	0	46,396	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	4,999,146	5,163,312	10,162,458	0	10,162,458	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	4,999,146	5,163,312	10,162,458	0	10,162,458	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/28/2024 12:55 pm
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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	-82,007	1,645,368	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	1,040,893	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	82,950	1,898,622	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	307,467	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	41,760	6.00
7.00	00700	HOUSEKEEPING	0	247,847	7.00
8.00	00800	DIETARY	0	893,275	8.00
9.00	00900	NURSING ADMINISTRATION	0	184,805	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	121,633	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	51,941	12.00
13.00	01300	SOCIAL SERVICE	0	62,324	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	238,050	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	0	2,711,448	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	0	40.00
41.00	04100	LABORATORY	0	18,407	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	218,670	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	248,086	45.00
46.00	04600	SPEECH PATHOLOGY	0	43,749	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	142,660	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	46,396	71.00
73.00	07300	CMHC	0	0	73.00
<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)	943	10,163,401	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	943	10,163,401	100.00

RECLASSIFICATIONS

Provider No. : 315378

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

Worksheet A-6

Date/Time Prepared:  
5/28/2024 12:55 pm

		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. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/28/2024 12:55 pm
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		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
100.00	TOTALS			0	0	100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315378

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

Worksheet A-7

Date/Time Prepared:  
5/28/2024 12:55 pm

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	3,783,652	111,415	0	111,415	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	272,003	0	0	0	104,991	6.00
7.00 Subtotal (sum of lines 1-6)	4,055,655	111,415	0	111,415	104,991	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	4,055,655	111,415	0	111,415	104,991	9.00
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	3,895,067	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	167,012	0				
7.00 Subtotal (sum of lines 1-6)	4,062,079	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	4,062,079	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315378

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

Worksheet A-8

Date/Time Prepared:  
5/28/2024 12:55 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line No.	
			1.00	2.00	3.00	4.00
1.00 Investment income on restricted funds (chapter 2)	B	-2,288		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	26,707				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals		0			0.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Vending machines		0			0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)				UTILIZATION REVIEW - SNF	82.00	22.00
23.00 Depreciation--buildings and fixtures				OCAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00 Depreciation--movable equipment				OCAP REL COSTS - MOVABLE EQUIPMENT	2.00	24.00
25.00		0			0.00	25.00
25.01 DONATION	A	-1,500		ADMINISTRATIVE & GENERAL	4.00	25.01
25.04 PROMOTIONAL ADS	A	-21,874		ADMINISTRATIVE & GENERAL	4.00	25.04
25.07 PENALTIES	A	-102		ADMINISTRATIVE & GENERAL	4.00	25.07
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		943				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. : 315378

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

Worksheet A-8-1  
Parts I-11  
Date/Time Prepared:  
5/28/2024 12:55 pm

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00	
2.00	4.00	ADMINISTRATIVE & GENERAL	REALTY A&G COSTS	2.00	
3.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	DEPRECIATION	3.00	
4.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	INTEREST	4.00	
5.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	AMORTIZATION OF FIN COST	5.00	
6.00	0.00			6.00	
7.00	0.00			7.00	
8.00	0.00			8.00	
9.00	0.00			9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00	
		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
		4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		0	1,169,080	-1,169,080	1.00
2.00		106,426	0	106,426	2.00
3.00		228,610	0	228,610	3.00
4.00		826,631	0	826,631	4.00
5.00		34,120	0	34,120	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.			26,707	10.00

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

Provider No. : 315378

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

Worksheet A-8-1  
Parts I-III  
Date/Time Prepared:  
5/28/2024 12:55 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

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

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

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

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

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

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

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

1.00		129 MORRIS TURNPIKE REALTY	100.00	REALTY	1.00
2.00			0.00		2.00
3.00			0.00		3.00
4.00			0.00		4.00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315378

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,645,368	1,645,368			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	1,040,893	0	0	1,040,893	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,898,622	0	0	191,989	2,090,611 4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	307,467	0	0	18,325	325,792 5.00
6.00 00600	LAUNDRY & LINEN SERVICE	41,760	0	0	6,571	48,331 6.00
7.00 00700	HOUSEKEEPING	247,847	0	0	48,031	295,878 7.00
8.00 00800	DIETARY	893,275	0	0	126,169	1,019,444 8.00
9.00 00900	NURSING ADMINISTRATION	184,805	0	0	38,479	223,284 9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	121,633	0	0	0	121,633 10.00
11.00 01100	PHARMACY	0	0	0	0	0 11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	51,941	0	0	0	51,941 12.00
13.00 01300	SOCIAL SERVICE	62,324	0	0	12,977	75,301 13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0 14.00
15.00 01500	PATIENT ACTIVITIES	238,050	0	0	43,574	281,624 15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	2,711,448	1,626,006	0	448,509	4,785,963 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	18,407	0	0	0	18,407 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	218,670	19,362	0	45,511	283,543 44.00
45.00 04500	OCCUPATIONAL THERAPY	248,086	0	0	51,649	299,735 45.00
46.00 04600	SPEECH PATHOLOGY	43,749	0	0	9,109	52,858 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	142,660	0	0	0	142,660 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FQHC	0	0	0	0	0 62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	46,396	0	0	0	46,396 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
<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)	10,163,401	1,645,368	0	1,040,893	10,163,401 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	10,163,401	1,645,368	0	1,040,893	10,163,401 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315378

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	2,090,611				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	84,370	410,162			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	12,516	0	60,847		6.00	
7.00	00700	HOUSEKEEPING	76,624	0	0	372,502	7.00	
8.00	00800	DIETARY	264,005	0	0	0	1,283,449	8.00
9.00	00900	NURSING ADMINISTRATION	57,824	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	31,499	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	13,451	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	19,501	0	0	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	72,932	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	1,239,422	405,335	60,847	368,119	1,283,449	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	4,767	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	73,429	4,827	0	4,383	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	77,622	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	13,689	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	36,945	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	12,015	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
<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)	2,090,611	410,162	60,847	372,502	1,283,449	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	2,090,611	410,162	60,847	372,502	1,283,449	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315378

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	281,108					9.00
10.00	01000	0	153,132				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	65,392		12.00
13.00	01300	0	0	0	0	94,802	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	281,108	70,474	0	65,392	94,802	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	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	82,658	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<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		281,108	153,132	0	65,392	94,802	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		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		281,108	153,132	0	65,392	94,802	100.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315378

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total	
		14.00 15.00 16.00 17.00 18.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	354,556			15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	0	354,556	9,009,467	0	9,009,467 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	23,174	0	23,174 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	0	366,182	0	366,182 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	377,357	0	377,357 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	66,547	0	66,547 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	262,263	0	262,263 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	58,411	0	58,411 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
<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)	0	354,556	10,163,401	0	10,163,401 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	0	354,556	10,163,401	0	10,163,401 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315378

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00	00300	EMPLOYEE BENEFITS	0	0	0	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	0	0	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	0	0	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	00700	HOUSEKEEPING	0	0	0	7.00
8.00	00800	DIETARY	0	0	0	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	SKILLED NURSING FACILITY	0	1,626,006	0	30.00
31.00	03100	NURSING FACILITY	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	33.00
<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	19,362	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
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60.00	06000	CLINIC	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	61.00
62.00	06200	FOHC	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	71.00
73.00	07300	CMHC	0	0	0	73.00
<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)	0	1,645,368	0	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			0	98.00
99.00		Negative Cost Centers			0	99.00
100.00		TOTAL	0	1,645,368	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315378

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	0			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	0		6.00
7.00	00700	HOUSEKEEPING	0	0	0	0	7.00
8.00	00800	DIETARY	0	0	0	0	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	0	0	0	0	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	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	73.00
<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)	0	0	0	0	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	0	0	0	0	99.00
100.00		TOTAL	0	0	0	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315378

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	0					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	0	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<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	0	0	0	0	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		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		0	0	0	0	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315378

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
		PATIENT ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	0			15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	0	0	1,626,006	0	1,626,006
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	19,362	0	19,362
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	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC					62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
<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)	0	0	1,645,368	0	1,645,368
<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	0	0	1,645,368	0	1,645,368

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315378

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	42,490					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	4,999,146			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	0	922,073	-2,090,611	8,072,790	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	0	88,012	0	325,792	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	0	31,557	0	48,331	6.00
7.00 00700	HOUSEKEEPING	0	0	230,680	0	295,878	7.00
8.00 00800	DIETARY	0	0	605,958	0	1,019,444	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	184,805	0	223,284	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	121,633	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	51,941	12.00
13.00 01300	SOCIAL SERVICE	0	0	62,324	0	75,301	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	0	0	209,276	0	281,624	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	SKILLED NURSING FACILITY	41,990	0	2,154,075	0	4,785,963	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	18,407	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	500	0	218,580	0	283,543	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	248,057	0	299,735	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	43,749	0	52,858	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	142,660	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	46,396	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
<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)	42,490	0	4,999,146	-2,090,611	8,072,790	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)	1,645,368	0	1,040,893		2,090,611	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	38.723653	0.000000	0.208214		0.258970	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315378

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION  (DIRECT NURSING)	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	42,490					6.00
7.00	00700	0	23,830				7.00
8.00	00800	0	0	42,490			8.00
9.00	00900	0	0	0	71,490		9.00
10.00	01000	0	0	0	0	94,998	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	41,990	23,830	41,990	71,490	94,998	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	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	500	0	500	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<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		42,490	23,830	42,490	71,490	94,998	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
102.00		410,162	60,847	372,502	1,283,449	281,108	102.00
103.00		9.653142	2.553378	8.766816	17.952847	2.959094	103.00
104.00		0	0	0	0	0	104.00
105.00		0.000000	0.000000	0.000000	0.000000	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315378

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

Worksheet B-1

Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	264,293					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	23,830			12.00
13.00	01300	0	0	0	23,830		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	121,633	0	23,830	23,830	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	142,660	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
<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		264,293	0	23,830	23,830	0	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
102.00		153,132	0	65,392	94,802	0	102.00
103.00		0.579402	0.000000	2.744104	3.978263	0.000000	103.00
104.00		0	0	0	0	0	104.00
105.00		0.000000	0.000000	0.000000	0.000000	0.000000	105.00



COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315378

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2024 12:55 pm

Cost Center Description		OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT_DAYS)	
		15.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01500	PATIENT ACTIVITIES	23,830
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	SKILLED NURSING FACILITY	23,830
31.00	03100	NURSING FACILITY	0
32.00	03200	ICF/IID	0
33.00	03300	OTHER LONG TERM CARE	0
<b>ANCILLARY SERVICE COST CENTERS</b>			
40.00	04000	RADIOLOGY	0
41.00	04100	LABORATORY	0
42.00	04200	INTRAVENOUS THERAPY	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0
44.00	04400	PHYSICAL THERAPY	0
45.00	04500	OCCUPATIONAL THERAPY	0
46.00	04600	SPEECH PATHOLOGY	0
47.00	04700	ELECTROCARDIOLOGY	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0
51.00	05100	SUPPORT SURFACES	0
<b>OUTPATIENT SERVICE COST CENTERS</b>			
60.00	06000	CLINIC	0
61.00	06100	RURAL HEALTH CLINIC	0
62.00	06200	FOHC	0
<b>OTHER REIMBURSABLE COST CENTERS</b>			
70.00	07000	HOME HEALTH AGENCY COST	0
71.00	07100	AMBULANCE	0
73.00	07300	CMHC	0
<b>SPECIAL PURPOSE COST CENTERS</b>			
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0
81.00	08100	INTEREST EXPENSE	0
82.00	08200	UTILIZATION REVIEW - SNF	0
83.00	08300	HOSPICE	0
89.00		SUBTOTALS (sum of lines 1-84)	23,830
<b>NONREIMBURSABLE COST CENTERS</b>			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0
91.00	09100	BARBER AND BEAUTY SHOP	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0
93.00	09300	NONPAID WORKERS	0
94.00	09400	PATIENTS LAUNDRY	0
98.00		Cross Foot Adjustments	0
99.00		Negative Cost Centers	0
102.00		Cost to be allocated (per Wkst. B, Part I)	354,556
103.00		Unit cost multiplier (Wkst. B, Part I)	14.878556
104.00		Cost to be allocated (per Wkst. B, Part II)	0
105.00		Unit cost multiplier (Wkst. B, Part II)	0.000000

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315378

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

Worksheet C

Date/Time Prepared:  
5/28/2024 12:55 pm

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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00	04000	RADIOLOGY	0	0	0.000000	40.00
41.00	04100	LABORATORY	23,174	11,930	1.942498	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	366,182	215,483	1.699354	44.00
45.00	04500	OCCUPATIONAL THERAPY	377,357	244,543	1.543111	45.00
46.00	04600	SPEECH PATHOLOGY	66,547	43,129	1.542976	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	262,263	223,361	1.174166	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FQHC				62.00
71.00	07100	AMBULANCE	58,411	46,396	1.258966	71.00
100.00		Total	1,153,934	784,842		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/28/2024 12:55 pm
		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)	
		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	1.942498	11,930	0	23,174	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	1.699354	204,015	0	346,694	0 44.00
45.00	04500 OCCUPATIONAL THERAPY	1.543111	221,351	0	341,569	0 45.00
46.00	04600 SPEECH PATHOLOGY	1.542976	35,319	0	54,496	0 46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.174166	217,891	0	255,840	0 49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0 50.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	0 51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
60.00	06000 CLINIC	0.000000	0	0	0	0 60.00
61.00	06100 RURAL HEALTH CLINIC					61.00
62.00	06200 FQHC					62.00
71.00	07100 AMBULANCE (2)	1.258966		0		0 71.00
100.00	Total (Sum of lines 40 - 71)		690,506	0	1,021,773	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. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/28/2024 12:55 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description			1.00	
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PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.174166	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	0	3.00

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

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	23,174	0	0.000000	23,174	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	366,182	0	0.000000	346,694	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	377,357	0	0.000000	341,569	0	45.00
46.00	04600	SPEECH PATHOLOGY	66,547	0	0.000000	54,496	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	262,263	0	0.000000	255,840	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	1,095,523	0		1,021,773	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/28/2024 12:55 pm
	Title XVIII	Skilled Nursing Facility	PPS

	1.00	
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PART I CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1.00	Inpatient days including private room days	23,830	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	4,711	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	9,009,467	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	9,468,992	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.951471	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)	9,009,467	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	378.07	16.00
17.00	Program routine service cost (Line 3 times line 16)	1,781,088	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)	1,781,088	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	1,626,006	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	68.23	21.00
22.00	Program capital related cost (Line 3 times line 21)	321,432	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,459,656	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)	1,459,656	25.00
26.00	Enter the per diem limitation (1)		26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00

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

	1.00	
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PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days	23,830	1.00
2.00	Program inpatient days (see instructions)	4,711	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)	0.197692	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. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/28/2024 12:55 pm
		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)		2,824,507	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		2,824,507	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		0	5.00
6.00	Allowable bad debts (From your records)		490,600	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		213,296	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		110,802	8.00
9.00	Recovery of bad debts - for statistical records only		138,642	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		0	11.00
12.00	Interim payments (See instructions)		2,472,549	12.00
13.00	Tentative adjustment		2,378,556	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		2,773	14.75
14.99	Sequestration amount (see instructions)		46,678	14.99
15.00	Balance due provider/program (see Instructions)		44,542	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)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315378	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/28/2024 12:55 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		2,378,556		0
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		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				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		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		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)		2,378,556		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
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)				0
6.01	PROGRAM TO PROVIDER		44,542		0
6.02	PROVIDER TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,423,098		0
			Contractor Name		Contractor Number
			1.00	2.00	
8.00	Name of Contractor				0

(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. : 315378

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

Worksheet G

Date/Time Prepared:  
5/28/2024 12:55 pm

		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	157,501	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,241,021	0	0	0	4.00
5.00	Other receivables	18,856	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-253,285	0	0	0	6.00
7.00	Inventory	14,161	0	0	0	7.00
8.00	Prepaid expenses	396,206	0	0	0	8.00
9.00	Other current assets	59,555	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>3,634,015</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	3,895,067	0	0	0	15.00
16.00	Less Accumulated depreciation	-1,780,437	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	167,012	0	0	0	23.00
24.00	Less: Accumulated depreciation	-110,851	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>2,170,791</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	6,058	0	0	0	30.00
31.00	Due from owners/officers	994,525	0	0	0	31.00
32.00	Other assets	512,607	0	0	0	32.00
33.00	<b>TOTAL OTHER ASSETS (Sum of lines 29 - 32)</b>	<b>1,513,190</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>7,317,996</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	2,324,920	0	0	0	35.00
36.00	Salaries, wages, and fees payable	192,441	0	0	0	36.00
37.00	Payroll taxes payable	312,787	0	0	0	37.00
38.00	Notes & loans payable (Short term)	1,014,619	0	0	0	38.00
39.00	Deferred income	360,664	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	0	0	0	0	42.00
43.00	<b>TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)</b>	<b>4,205,431</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	846	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	5,564,833	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>5,565,679</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>9,771,110</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-2,453,114	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>-2,453,114</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>7,317,996</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>



STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315378

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

Worksheet G-1

Date/Time Prepared:  
5/28/2024 12:55 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,256,406			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-1,196,711				2.00
3.00	Total (sum of line 1 and line 2)		-2,453,117			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDING	3		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		3			0	10.00
11.00	Subtotal (line 3 plus line 10)		-2,453,114			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-2,453,114			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	ROUNDING		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 5 - 9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)						12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315378

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

Worksheet G-2  
Parts I-III  
Date/Time Prepared:  
5/28/2024 12:55 pm

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	9,468,992		9,468,992	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	407		407	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	9,469,399		9,469,399	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	784,842	0	784,842	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	648	0	648	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	10,254,889	0	10,254,889	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)			10,162,458	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)			10,162,458	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315378

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

Worksheet G-3

Date/Time Prepared:  
5/28/2024 12:55 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	10,254,889	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,299,945	2.00
3.00	Net patient revenues (Line 1 minus line 2)	8,954,944	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	10,162,458	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,207,514	5.00
<b>Other income:</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,288	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	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PRIOR YEAR	15	24.00
24.50	COVID-19 PHE Funding	8,500	24.50
25.00	Total other income (Sum of lines 6 - 24)	10,803	25.00
26.00	Total (Line 5 plus line 25)	-1,196,711	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-1,196,711	31.00