

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: 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/31/2024 10:53 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____ 6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SYCAMORE REHAB & ASSISTED LIVING ( 315529 ) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00 SKILLED NURSING FACILITY	0	123,595	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	123,595	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. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:53 am				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 1 SOUTH RIDGEDALE AVE	PO Box:				1.00		
2.00	City: EAST HANOVER	State: NJ	Zip Code: 07936			2.00		
3.00	County: MORRIS	CBSA Code: 35084	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
SNF and SNF-Based Component Identification:								
4.00	SNF	SYCAMORE REHAB & ASSISTED LIVING	315529	05/14/2020	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)			5			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					727,340		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					727,340		23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility					N		29.00
30.00	Nursing Facility					N		30.00
31.00	ICF/IID					N		31.00
32.00	SNF-Based HHA					N		32.00
33.00	SNF-Based RHC					N		33.00
34.00	SNF-Based FQHC					N		34.00
35.00	SNF-Based CMHC					N		35.00
36.00	SNF-Based OLTC					N		36.00
				Y/N				
				1.00		2.00		
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.							39.00
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:		0	0	0		41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/31/2024 10:53 am
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		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	N	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.		44.00
	1.00	2.00	3.00
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.			
45.00	Name:	Contractor's Name:	Contractor's Number:
46.00	Street:	PO Box:	
47.00	City:	State:	Zip Code:

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/31/2024 10:53 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)		N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.		N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.		N		8.00
			Y/N		
			1.00		
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
			Part A		Part B
			Description	Date	Y/N
			0	1.00	2.00
			1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		Y	05/23/2024	Y
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		N		N
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		N
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		N		N
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		N		N
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		N		N

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

Provider No. : 315529

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/31/2024 10:53 am

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

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

Provider No. : 315529

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/31/2024 10:53 am

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	05/23/2024	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PREPARER	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

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

Provider No. : 315529

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

Worksheet S-3  
 Part I  
 Date/Time Prepared:  
 5/31/2024 10:53 am

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	86	31,390	0	11,871	3,055	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	37	13,505				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	123	44,895	0	11,871	3,055	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	11,138	26,064	0	386	19	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	8,399	8,399				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	19,537	34,463	0	386	19	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	30	435	0.00	30.75	160.79	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	30	435	0.00	30.75	160.79	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	59.92	0	272	12	139	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	79.23	0	272	12	139	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	423	106.30	0.00		1.00	
2.00	NURSING FACILITY	0	0.00	0.00		2.00	
3.00	ICF/IID	0	0.00	0.00		3.00	
4.00	HOME HEALTH AGENCY COST					4.00	
5.00	Other Long Term Care	0	27.00	0.00		5.00	
6.00	SNF-Based CMHC					6.00	
7.00	HOSPICE	0	0.00	0.00		7.00	
8.00	Total (Sum of lines 1-7)	423	133.30	0.00		8.00	

Provider No. : 315529

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
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	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - DIRECT SALARIES</b>						
<b>SALARIES</b>						
1.00	Total salaries (See Instructions)	8,360,679	0	8,360,679	277,409.00	30.14
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	8,360,679	0	8,360,679	277,409.00	30.14
7.00	Other Long Term Care	365,557	0	365,557	19,213.00	19.03
8.00	HOME HEALTH AGENCY COST					
9.00	CMHC					
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	365,557	0	365,557	19,213.00	19.03
13.00	Total Adjusted Salaries (line 6 minus line 12)	7,995,122	0	7,995,122	258,196.00	30.97
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	902,877	0	902,877	22,694.00	39.78
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	1,500,535	0	1,500,535		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	65,983	0	65,983		
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)	1,434,552	0	1,434,552		



SNF WAGE INDEX INFORMATION

Provider No. : 315529

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/31/2024 10:53 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - OVERHEAD COST - DIRECT SALARIES</b>						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	774,447	0	774,447	17,107.00	2.00
3.00	Plant Operation, Maintenance & Repairs	66,524	0	66,524	2,484.00	3.00
4.00	Laundry & Linen Service	62,370	0	62,370	3,971.00	4.00
5.00	Housekeeping	492,729	0	492,729	25,691.00	5.00
6.00	Dietary	749,263	0	749,263	34,902.00	6.00
7.00	Nursing Administration	1,117,510	0	1,117,510	29,203.00	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	97,114	0	97,114	2,289.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	263,645	0	263,645	11,828.00	13.00
14.00	Total (sum lines 1 thru 13)	3,623,602	0	3,623,602	127,475.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2024 10:53 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		23	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)		539,410	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		1,405	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		16,190	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		134,253	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		804,578	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		4,676	19.00
20.00	State or Federal Unemployment Taxes		0	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)		1,500,535	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. : 315529

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/31/2024 10:53 am

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	732,249	132,171	864,420	15,639.00	55.27	1.00
2.00	Licensed Practical Nurses (LPNs)	1,323,649	238,919	1,562,568	35,605.00	43.89	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,263,232	228,013	1,491,245	55,112.00	27.06	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,319,130	599,103	3,918,233	106,356.00	36.84	4.00
5.00	Physical Therapists	404,100	72,940	477,040	7,570.00	63.02	5.00
6.00	Physical Therapy Assistants	153,335	27,677	181,012	4,164.00	43.47	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	220,916	39,875	260,791	5,287.00	49.33	8.00
9.00	Occupational Therapy Assistants	179,296	32,363	211,659	5,229.00	40.48	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	94,744	17,101	111,845	2,115.00	52.88	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)	234,508		234,508	3,994.00	58.72	14.00
15.00	Licensed Practical Nurses (LPNs)	187,581		187,581	4,952.00	37.88	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	480,788		480,788	13,749.00	34.97	16.00
17.00	Total Nursing (sum of lines 14 through 16)	902,877		902,877	22,695.00	39.78	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315529

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

Worksheet S-7  
Date/Time Prepared:  
5/31/2024 10:53 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315529

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

Worksheet S-7

Date/Time Prepared:  
5/31/2024 10:53 am

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315529

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

Worksheet A  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		3,131,289	0	3,131,289	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,508,958	0	1,508,958	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	774,447	2,062,381	0	2,836,828	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	66,524	485,575	0	552,099	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	62,370	4,155	0	66,525	6.00
7.00	00700	HOUSEKEEPING	492,729	79,866	0	572,595	7.00
8.00	00800	DIETARY	749,263	448,922	0	1,198,185	8.00
9.00	00900	NURSING ADMINISTRATION	1,117,510	0	0	1,117,510	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	255,229	0	255,229	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	97,114	0	0	97,114	13.00
15.00	01500	PATIENT ACTIVITIES	263,645	72,142	0	335,787	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	3,319,130	1,013,472	0	4,332,602	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	365,557	0	0	365,557	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	RADIOLOGY	0	59,546	0	59,546	40.00
41.00	04100	LABORATORY	0	46,783	0	46,783	41.00
42.00	04200	INTRAVENOUS THERAPY	0	148,496	0	148,496	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	31,115	0	31,115	43.00
44.00	04400	PHYSICAL THERAPY	557,434	17,123	0	574,557	44.00
45.00	04500	OCCUPATIONAL THERAPY	400,212	0	0	400,212	45.00
46.00	04600	SPEECH PATHOLOGY	94,744	12,975	0	107,719	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	462,952	0	462,952	49.00
51.00	05100	SUPPORT SURFACES	0	32,704	0	32,704	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	AMBULANCE	0	20,480	0	20,480	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	8,360,679	9,894,163	0	18,254,842	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
100.00		TOTAL	8,360,679	9,894,163	0	18,254,842	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315529

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

Worksheet A  
Date/Time Prepared:  
5/31/2024 10:53 am

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	-1,000,040	2,131,249	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,508,958	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-487,529	2,349,299	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	552,099	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	66,525	6.00
7.00	00700	HOUSEKEEPING	0	572,595	7.00
8.00	00800	DIETARY	0	1,198,185	8.00
9.00	00900	NURSING ADMINISTRATION	0	1,117,510	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	255,229	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	97,114	13.00
15.00	01500	PATIENT ACTIVITIES	0	335,787	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	-32,500	4,300,102	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	365,557	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	0	59,546	40.00
41.00	04100	LABORATORY	0	46,783	41.00
42.00	04200	INTRAVENOUS THERAPY	0	148,496	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	31,115	43.00
44.00	04400	PHYSICAL THERAPY	0	574,557	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	400,212	45.00
46.00	04600	SPEECH PATHOLOGY	0	107,719	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	462,952	49.00
51.00	05100	SUPPORT SURFACES	0	32,704	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
71.00	07100	AMBULANCE	0	20,480	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	-1,520,069	16,734,773	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
100.00		TOTAL	-1,520,069	16,734,773	100.00

Provider No. : 315529

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

Worksheet A-6

Date/Time Prepared:  
5/31/2024 10:53 am

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

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



Provider No. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/31/2024 10:53 am
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		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
100.00	TOTALS			0	0	100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315529

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

Worksheet A-7

Date/Time Prepared:  
5/31/2024 10:53 am

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	38,984	47,536	0	47,536	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,626,527	75,325	0	75,325	6.00
7.00	Subtotal (sum of lines 1-6)	1,665,511	122,861	0	122,861	7.00
8.00	Reconciling Items	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	1,665,511	122,861	0	122,861	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			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	86,520	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	1,701,852	0			6.00
7.00	Subtotal (sum of lines 1-6)	1,788,372	0			7.00
8.00	Reconciling Items	0	0			8.00
9.00	Total (line 7 minus line 8)	1,788,372	0			9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315529

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

Worksheet A-8

Date/Time Prepared:  
5/31/2024 10:53 am

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line No.
			1.00	2.00
1.00 Investment income on restricted funds (chapter 2)	B	-28	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	-990,609		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			0*** Cost Center Deleted ***	2.00 24.00
25.00 CONTRIBUTIONS	A	-5,860	ADMINISTRATIVE & GENERAL	4.00 25.00
25.01 CONTRACT PROF SRV - PHYSICIAN SNF	A	-32,500	SKILLED NURSING FACILITY	30.00 25.01
25.02 RESIDENT REPLACEMENT ITEMS	A	-225	ADMINISTRATIVE & GENERAL	4.00 25.02
25.03 MARKETING	A	-244,302	ADMINISTRATIVE & GENERAL	4.00 25.03
25.07 OTHER INCOME	B	-246,545	ADMINISTRATIVE & GENERAL	4.00 25.07
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,520,069		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. : 315529

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

Worksheet A-8-1  
Parts I-II  
Date/Time Prepared:  
5/31/2024 10:53 am

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00	
2.00	4.00	ADMINISTRATIVE & GENERAL	REALTY ADMIN COSTS	2.00	
3.00	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	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	1,564,227	2,564,239	-1,000,012	1.00	
2.00	9,403	0	9,403	2.00	
3.00	0	0	0	3.00	
4.00	0	0	0	4.00	
5.00	0	0	0	5.00	
6.00	0	0	0	6.00	
7.00	0	0	0	7.00	
8.00	0	0	0	8.00	
9.00	0	0	0	9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00	
	1,573,630	2,564,239	-990,609		

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/31/2024 10:53 am
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Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	B	CHR MANAGEMENT, LLC	25.00	1.00
2.00	B	SYCAMORE ELDERCARE LLC	75.00	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	LIVIA PROPCO	60.00	REALTY	1.00
2.00	LIVIA PROPCO	40.00	REALTY	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. : 315529

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	2,131,249	2,131,249			1.00
3.00 00300	EMPLOYEE BENEFITS	1,508,958	0	1,508,958		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,349,299	145,523	139,775	2,634,597	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	552,099	15,558	12,006	579,663	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	66,525	25,726	11,257	103,508	6.00
7.00 00700	HOUSEKEEPING	572,595	25,726	88,929	687,250	7.00
8.00 00800	DIETARY	1,198,185	78,938	135,229	1,412,352	8.00
9.00 00900	NURSING ADMINISTRATION	1,117,510	43,513	201,692	1,362,715	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	255,229	21,226	0	276,455	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	5,519	0	5,519	12.00
13.00 01300	SOCIAL SERVICE	97,114	2,314	17,527	116,955	13.00
15.00 01500	PATIENT ACTIVITIES	335,787	17,766	47,583	401,136	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	4,300,102	1,065,188	599,045	5,964,335	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	365,557	424,514	65,977	856,048	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	59,546	0	0	59,546	40.00
41.00 04100	LABORATORY	46,783	0	0	46,783	41.00
42.00 04200	INTRAVENOUS THERAPY	148,496	0	0	148,496	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	31,115	0	0	31,115	43.00
44.00 04400	PHYSICAL THERAPY	574,557	137,733	100,607	812,897	44.00
45.00 04500	OCCUPATIONAL THERAPY	400,212	87,641	72,231	560,084	45.00
46.00 04600	SPEECH PATHOLOGY	107,719	25,046	17,100	149,865	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	462,952	0	0	462,952	49.00
51.00 05100	SUPPORT SURFACES	32,704	0	0	32,704	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	20,480	0	0	20,480	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	16,734,773	2,121,931	1,508,958	16,725,455	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	9,318	0	9,318	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	16,734,773	2,131,249	1,508,958	16,734,773	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315529

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	687,972				5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	8,983	131,831			6.00	
7.00	00700	HOUSEKEEPING	8,983	0	824,645		7.00	
8.00	00800	DIETARY	27,565	0	33,927	1,737,741	8.00	
9.00	00900	NURSING ADMINISTRATION	15,194	0	18,701	0	1,651,232	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	7,412	0	9,123	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	1,927	0	2,372	0	0	12.00
13.00	01300	SOCIAL SERVICE	808	0	994	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	6,204	0	7,636	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	371,958	99,702	457,807	1,314,235	1,437,255	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	148,238	32,129	182,452	423,506	213,977	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	48,096	0	59,196	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	30,604	0	37,667	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	8,746	0	10,765	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	684,718	131,831	820,640	1,737,741	1,651,232	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	3,254	0	4,005	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	687,972	131,831	824,645	1,737,741	1,651,232	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315529

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
	10.00	12.00	13.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	344,645				10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	10,849			12.00
13.00 01300	SOCIAL SERVICE	0	0	140,610		13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	489,928	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	117,296	8,205	106,342	370,527	11,362,086 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	2,644	34,268	119,401	2,172,615 33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	0	70,672 40.00
41.00 04100	LABORATORY	0	0	0	0	55,524 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	176,242 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	36,929 43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	1,072,078 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	733,006 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	197,378 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	227,349	0	0	0	776,803 49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	38,815 51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	0	24,307 71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	344,645	10,849	140,610	489,928	16,716,455 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	18,318 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	344,645	10,849	140,610	489,928	16,734,773 100.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315529

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description		Post Stepdown Adjustments	Total	
		17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	SKILLED NURSING FACILITY	0 11,362,086	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 2,172,615	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00	04000	RADIOLOGY	0 70,672	40.00
41.00	04100	LABORATORY	0 55,524	41.00
42.00	04200	INTRAVENOUS THERAPY	0 176,242	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0 36,929	43.00
44.00	04400	PHYSICAL THERAPY	0 1,072,078	44.00
45.00	04500	OCCUPATIONAL THERAPY	0 733,006	45.00
46.00	04600	SPEECH PATHOLOGY	0 197,378	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	0 776,803	49.00
51.00	05100	SUPPORT SURFACES	0 38,815	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00	07100	AMBULANCE	0 24,307	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0 0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	0 16,716,455	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 18,318	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0 0	92.00
93.00	09300	NONPAID WORKERS	0 0	93.00
94.00	09400	PATIENTS LAUNDRY	0 0	94.00
98.00		Cross Foot Adjustments	0 0	98.00
99.00		Negative Cost Centers	0 0	99.00
100.00		TOTAL	0 16,734,773	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315529

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS	ADM NI STRATI VE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	2A	3.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0		3.00
4.00 00400	ADM NI STRATI VE & GENERAL	0	145,523	145,523	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	15,558	15,558	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	25,726	25,726	0	6.00
7.00 00700	HOUSEKEEPING	0	25,726	25,726	0	7.00
8.00 00800	DI ETARY	0	78,938	78,938	0	8.00
9.00 00900	NURSI NG ADM NI STRATI ON	0	43,513	43,513	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	21,226	21,226	0	10.00
12.00 01200	MEDI CAL RECORDS & LIBRARY	0	5,519	5,519	0	12.00
13.00 01300	SOCI AL SERVI CE	0	2,314	2,314	0	13.00
15.00 01500	PATI ENT ACTI VI TI ES	0	17,766	17,766	0	15.00
<b>INPAT IENT ROUT INE SERVI CE COST CENTERS</b>						
30.00 03000	SKI LLED NURSI NG FACI LI TY	0	1,065,188	1,065,188	0	30.00
31.00 03100	NURSI NG FACI LI TY	0	0	0	0	31.00
32.00 03200	ICF/I ID	0	0	0	0	32.00
33.00 03300	OT HER LONG TERM CARE	0	424,514	424,514	0	33.00
<b>ANCI LLARY SERVI CE COST CENTERS</b>						
40.00 04000	RADI OLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRA VENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (I NHALATI ON) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSI CAL THERAPY	0	137,733	137,733	0	44.00
45.00 04500	OCCUPATI ONAL THERAPY	0	87,641	87,641	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	25,046	25,046	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATI ENTS	0	0	0	0	49.00
51.00 05100	SUPP ORT SURFACES	0	0	0	0	51.00
<b>OT HER REI MBURSA BLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	0	71.00
<b>SPECI AL PURPO SE COST CENTERS</b>						
80.00 08000	MALPRACTI CE PREMI UMS & PAI D LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTI LI ZATI ON REVI EW - SNF					82.00
83.00 08300	HOSPI CE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	2,121,931	2,121,931	0	89.00
<b>NONREI MBURSA BLE 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	9,318	9,318	0	91.00
92.00 09200	PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	92.00
93.00 09300	NONPAI D WORKERS	0	0	0	0	93.00
94.00 09400	PATI ENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
100.00	TOTAL	0	2,131,249	2,131,249	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315529

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	21,541				5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	281	27,075			6.00	
7.00	00700	HOUSEKEEPING	281	0	33,100		7.00	
8.00	00800	DIETARY	863	0	1,362	95,740	8.00	
9.00	00900	NURSING ADMINISTRATION	476	0	751	0	58,805	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	232	0	366	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	60	0	95	0	0	12.00
13.00	01300	SOCIAL SERVICE	25	0	40	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	194	0	306	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	11,648	20,477	18,376	72,407	51,185	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	4,641	6,598	7,323	23,333	7,620	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1,506	0	2,376	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	958	0	1,512	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	274	0	432	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	21,439	27,075	32,939	95,740	58,805	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	102	0	161	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	21,541	27,075	33,100	95,740	58,805	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315529

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal		
	10.00	12.00	13.00	15.00			16.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00	
3.00 00300 EMPLOYEE BENEFITS						3.00	
4.00 00400 ADMINISTRATIVE & GENERAL						4.00	
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00	
6.00 00600 LAUNDRY & LINEN SERVICE						6.00	
7.00 00700 HOUSEKEEPING						7.00	
8.00 00800 DIETARY						8.00	
9.00 00900 NURSING ADMINISTRATION						9.00	
10.00 01000 CENTRAL SERVICES & SUPPLY	24,677					10.00	
12.00 01200 MEDICAL RECORDS & LIBRARY	0	5,731				12.00	
13.00 01300 SOCIAL SERVICE	0	0	3,586			13.00	
15.00 01500 PATIENT ACTIVITIES	0	0	0	22,406		15.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 SKILLED NURSING FACILITY	8,399	4,334	2,712	16,945	1,333,223	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	1,397	874	5,461	490,596	33.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00 04000 RADIOLOGY	0	0	0	0	615	40.00	
41.00 04100 LABORATORY	0	0	0	0	483	41.00	
42.00 04200 INTRAVENOUS THERAPY	0	0	0	0	1,533	42.00	
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	321	43.00	
44.00 04400 PHYSICAL THERAPY	0	0	0	0	150,005	44.00	
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	0	95,892	45.00	
46.00 04600 SPEECH PATHOLOGY	0	0	0	0	27,299	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	16,278	0	0	0	21,056	49.00	
51.00 05100 SUPPORT SURFACES	0	0	0	0	338	51.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00 07100 AMBULANCE	0	0	0	0	211	71.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00	
81.00 08100 INTEREST EXPENSE						81.00	
82.00 08200 UTILIZATION REVIEW - SNF						82.00	
83.00 08300 HOSPICE	0	0	0	0	0	83.00	
89.00	SUBTOTALS (sum of lines 1-84)	24,677	5,731	3,586	22,406	2,121,572	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	9,677	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	98.00	
99.00	Negative Cost Centers	0	0	0	0	99.00	
100.00	TOTAL	24,677	5,731	3,586	22,406	2,131,249	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315529

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description		Post Step-Down Adjustments	Total	
		17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	SKILLED NURSING FACILITY	0	1,333,223
31.00	03100	NURSING FACILITY	0	0
32.00	03200	ICF/IID	0	0
33.00	03300	OTHER LONG TERM CARE	0	490,596
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00	04000	RADIOLOGY	0	615
41.00	04100	LABORATORY	0	483
42.00	04200	INTRAVENOUS THERAPY	0	1,533
43.00	04300	OXYGEN (INHALATION) THERAPY	0	321
44.00	04400	PHYSICAL THERAPY	0	150,005
45.00	04500	OCCUPATIONAL THERAPY	0	95,892
46.00	04600	SPEECH PATHOLOGY	0	27,299
47.00	04700	ELECTROCARDIOLOGY	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0	21,056
51.00	05100	SUPPORT SURFACES	0	338
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00	07100	AMBULANCE	0	211
<b>SPECIAL PURPOSE COST CENTERS</b>				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	0
89.00		SUBTOTALS (sum of lines 1-84)	0	2,121,572
<b>NONREIMBURSABLE COST CENTERS</b>				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0
91.00	09100	BARBER AND BEAUTY SHOP	0	9,677
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0
93.00	09300	NONPAID WORKERS	0	0
94.00	09400	PATIENTS LAUNDRY	0	0
98.00		Cross Foot Adjustments	0	0
99.00		Negative Cost Centers	0	0
100.00		TOTAL	0	2,131,249

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315529

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

Worksheet B-1  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	BLDGS & FIXTURES (SQUARE FEET)					
	1.00	3.00	4A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	100,409				1.00
3.00 00300	EMPLOYEE BENEFITS	0	8,360,679			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	6,856	774,447	-2,634,597	14,100,176	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	733	66,524	0	579,663	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,212	62,370	0	103,508	6.00
7.00 00700	HOUSEKEEPING	1,212	492,729	0	687,250	7.00
8.00 00800	DIETARY	3,719	749,263	0	1,412,352	8.00
9.00 00900	NURSING ADMINISTRATION	2,050	1,117,510	0	1,362,715	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	1,000	0	0	276,455	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	260	0	0	5,519	12.00
13.00 01300	SOCIAL SERVICE	109	97,114	0	116,955	13.00
15.00 01500	PATIENT ACTIVITIES	837	263,645	0	401,136	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	50,184	3,319,130	0	5,964,335	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	20,000	365,557	0	856,048	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	59,546	40.00
41.00 04100	LABORATORY	0	0	0	46,783	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	148,496	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	31,115	43.00
44.00 04400	PHYSICAL THERAPY	6,489	557,434	0	812,897	44.00
45.00 04500	OCCUPATIONAL THERAPY	4,129	400,212	0	560,084	45.00
46.00 04600	SPEECH PATHOLOGY	1,180	94,744	0	149,865	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	462,952	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	32,704	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	20,480	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	99,970	8,360,679	-2,634,597	14,090,858	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	439	0	0	9,318	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2,131,249	1,508,958		2,634,597	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	21.225677	0.180483		0.186849	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		145,523	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.010321	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315529

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

Worksheet B-1

Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)		
		6.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	34,463				6.00	
7.00	00700	HOUSEKEEPING	0	90,396			7.00	
8.00	00800	DIETARY	0	3,719	103,389		8.00	
9.00	00900	NURSING ADMINISTRATION	0	2,050	0	148,264	9.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	0	1,000	0	0	10.00	
12.00	01200	MEDICAL RECORDS & LIBRARY	0	260	0	0	12.00	
13.00	01300	SOCIAL SERVICE	0	109	0	0	13.00	
15.00	01500	PATIENT ACTIVITIES	0	837	0	0	15.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	26,064	50,184	78,192	129,051	238,852	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	8,399	20,000	25,197	19,213	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	6,489	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	4,129	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	1,180	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	462,952	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	34,463	89,957	103,389	148,264	701,804	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	439	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)	131,831	824,645	1,737,741	1,651,232	344,645	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	3.825291	9.122583	16.807794	11.137107	0.491084	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	27,075	33,100	95,740	58,805	24,677	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.785625	0.366167	0.926017	0.396624	0.035162	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315529

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

Worksheet B-1  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT DAYS)	
	12.00	13.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
3.00 00300 EMPLOYEE BENEFITS				3.00
4.00 00400 ADMINISTRATIVE & GENERAL				4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 00600 LAUNDRY & LINEN SERVICE				6.00
7.00 00700 HOUSEKEEPING				7.00
8.00 00800 DIETARY				8.00
9.00 00900 NURSING ADMINISTRATION				9.00
10.00 01000 CENTRAL SERVICES & SUPPLY				10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	34,463			12.00
13.00 01300 SOCIAL SERVICE	0	34,463		13.00
15.00 01500 PATIENT ACTIVITIES	0	0	34,463	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000 SKILLED NURSING FACILITY	26,064	26,064	26,064	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	8,399	8,399	8,399	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00 04000 RADIOLOGY	0	0	0	40.00
41.00 04100 LABORATORY	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	46.00
47.00 04700 ELECTROCARDIOLOGY	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00 07100 AMBULANCE	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00 08100 INTEREST EXPENSE				81.00
82.00 08200 UTILIZATION REVIEW - SNF				82.00
83.00 08300 HOSPICE	0	0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	34,463	34,463	34,463	89.00
<b>NONREIMBURSABLE COST CENTERS</b>				
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	94.00
98.00 Cross Foot Adjustments				98.00
99.00 Negative Cost Centers				99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	10,849	140,610	489,928	102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	0.314801	4.080028	14.216058	103.00
104.00 Cost to be allocated (per Wkst. B, Part II)	5,731	3,586	22,406	104.00
105.00 Unit cost multiplier (Wkst. B, Part II)	0.166294	0.104054	0.650147	105.00



RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/31/2024 10:53 am	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	70,672	30,710	2.301270 40.00
41.00	04100	LABORATORY	55,524	21,181	2.621406 41.00
42.00	04200	INTRAVENOUS THERAPY	176,242	74,245	2.373789 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	36,929	0	0.000000 43.00
44.00	04400	PHYSICAL THERAPY	1,072,078	2,066,435	0.518806 44.00
45.00	04500	OCCUPATIONAL THERAPY	733,006	2,254,071	0.325192 45.00
46.00	04600	SPEECH PATHOLOGY	197,378	221,506	0.891073 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	776,803	397,417	1.954630 49.00
51.00	05100	SUPPORT SURFACES	38,815	0	0.000000 51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	07100	AMBULANCE	24,307	0	0.000000 71.00
100.00		Total	3,181,754	5,065,565	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Provider No. : 315529

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/31/2024 10:53 am

Title XVIII (1)

Skilled Nursing  
Facility

PPS

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
			1.00	2.00	3.00	4.00		5.00
<b>PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST</b>								
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	2.301270	15,199	0	34,977	0	40.00
41.00	04100	LABORATORY	2.621406	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	2.373789	74,245	0	176,242	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.518806	1,443,555	0	748,925	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.325192	1,510,910	0	491,336	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.891073	134,271	0	119,645	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	1.954630	236,935	0	463,120	0	49.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		3,415,115	0	2,034,245	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. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/31/2024 10:53 am
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description						1.00	
PART II - APPORTIONMENT OF VACCINE COST							
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)				1.954630	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	70,672	0	0.000000	34,977	0 40.00
41.00	04100	LABORATORY	55,524	0	0.000000	0	0 41.00
42.00	04200	INTRAVENOUS THERAPY	176,242	0	0.000000	176,242	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	36,929	0	0.000000	0	0 43.00
44.00	04400	PHYSICAL THERAPY	1,072,078	0	0.000000	748,925	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	733,006	0	0.000000	491,336	0 45.00
46.00	04600	SPEECH PATHOLOGY	197,378	0	0.000000	119,645	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	776,803	0	0.000000	463,120	0 49.00
51.00	05100	SUPPORT SURFACES	38,815	0	0.000000	0	0 51.00
100.00		Total (Sum of lines 40 - 52)	3,157,447	0		2,034,245	0 100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-III Date/Time Prepared: 5/31/2024 10:53 am
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
<b>PART I CALCULATION OF INPATIENT ROUTINE COSTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days including private room days		26,064	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		11,871	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		11,362,086	5.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
6.00	General inpatient routine service charges		14,518,653	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.782585	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		11,362,086	15.00
<b>PROGRAM INPATIENT ROUTINE SERVICE COSTS</b>				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		435.93	16.00
17.00	Program routine service cost (Line 3 times line 16)		5,174,925	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)		5,174,925	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)		1,333,223	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		51.15	21.00
22.00	Program capital related cost (Line 3 times line 21)		607,202	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		4,567,723	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)		4,567,723	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

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

			1.00	
<b>PART II CALCULATION OF INPATIENT NURSING &amp; ALLIED HEALTH COSTS FOR PPS PASS-THROUGH</b>				
1.00	Total SNF inpatient days		26,064	1.00
2.00	Program inpatient days (see instructions)		11,871	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)		0.455456	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. : 315529	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/31/2024 10:53 am
		Title XVIII	Skilled Nursing Facility	PPS

			1.00	
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PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		9,066,354	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)		9,066,354	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		1,195,600	5.00
6.00	Allowable bad debts (From your records)		194,026	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		7,400	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		126,117	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		7,996,871	11.00
12.00	Interim payments (See instructions)		7,713,339	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		2,522	14.75
14.99	Sequestration amount (see instructions)		157,415	14.99
15.00	Balance due provider/program (see Instructions)		123,595	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		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. : 315529

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

Worksheet E-1

Date/Time Prepared:  
5/31/2024 10:53 am

Title XVIII

Skilled Nursing  
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		7,713,339		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		7,713,339		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		123,595		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,836,934		0	7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor					8.00

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

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

Provider No. : 315529

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

Worksheet G

Date/Time Prepared:  
5/31/2024 10:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>Assets</b>						
<b>CURRENT ASSETS</b>						
1.00	Cash on hand and in banks	93,192	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	3,123,691	0	0	0	4.00
5.00	Other receivables	8,300	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-1,055,021	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	66,388	0	0	0	8.00
9.00	Other current assets	-28,986	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>2,207,564</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	86,520	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	1,701,851	0	0	0	23.00
24.00	Less: Accumulated depreciation	-307,981	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	<b>TOTAL FIXED ASSETS (Sum of lines 12 - 27)</b>	<b>1,480,390</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	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	1,205,148	0	0	0	32.00
33.00	<b>TOTAL OTHER ASSETS (Sum of lines 29 - 32)</b>	<b>1,205,148</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>4,893,102</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	1,326,192	0	0	0	35.00
36.00	Salaries, wages, and fees payable	28,724	0	0	0	36.00
37.00	Payroll taxes payable	393,621	0	0	0	37.00
38.00	Notes & loans payable (Short term)	2,790,000	0	0	0	38.00
39.00	Deferred income	187,260	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	2,835,138	0	0	0	42.00
43.00	<b>TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)</b>	<b>7,560,935</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43.00</b>
<b>LONG TERM LIABILITIES</b>						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	<b>TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>TOTAL LIABILITIES (Sum of lines 43 and 50)</b>	<b>7,560,935</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-2,667,833	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>-2,667,833</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>4,893,102</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315529

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

Worksheet G-1

Date/Time Prepared:  
5/31/2024 10:53 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		-2,337,905		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-1,827,388			2.00
3.00	Total (sum of line 1 and line 2)		-4,165,293		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00	ADDITIONS	1,497,460		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		1,497,460		0	10.00
11.00	Subtotal (line 3 plus line 10)		-2,667,833		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-2,667,833		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	ADDITIONS		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. : 315529

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

Worksheet G-2  
Parts I-III  
Date/Time Prepared:  
5/31/2024 10:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	14,518,653		14,518,653	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	2,155,992		2,155,992	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	16,674,645		16,674,645	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	5,065,565	0	5,065,565	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	8,338	0	8,338	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	21,748,548	0	21,748,548	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)			18,254,842	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)			18,254,842	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315529

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

Worksheet G-3

Date/Time Prepared:  
5/31/2024 10:53 am

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	21,748,548	1.00
2.00	Less: contractual allowances and discounts on patients accounts	5,574,806	2.00
3.00	Net patient revenues (Line 1 minus line 2)	16,173,742	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	18,254,842	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-2,081,100	5.00
<b>Other income:</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	28	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	NON PATIENT REVENUE	246,545	24.00
24.01	BARBER BEAUTY	7,139	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	253,712	25.00
26.00	Total (Line 5 plus line 25)	-1,827,388	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)	-1,827,388	31.00