

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: 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/24/2024 1:32 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMPLETE CARE AT PARK PLACE (315362) 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.

1	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	1
	2	2		
	Shalom Stein	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.	
2	Signatory Printed Name	Shalom Stein		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	128,684	690	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	128,684	690	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. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 1:32 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 2 DEER PARK DRIVE	PO Box:				1.00		
2.00	City: MONMOUTH JUNCTION	State: NJ	Zip Code: 08852			2.00		
3.00	County: MIDDLESEX	CBSA Code: 35154	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
SNF and SNF-Based Component Identification:								
4.00	SNF	COMPLETE CARE AT PARK PLACE	315362	01/30/1997	N	P	P	
5.00	Nursing Facility							
6.00	ICF/IID							
7.00	SNF-Based HHA							
8.00	SNF-Based RHC							
9.00	SNF-Based FQHC							
10.00	SNF-Based CMHC							
11.00	SNF-Based OLTC							
12.00	SNF-Based HOSPICE							
13.00	SNF-Based CORF							
				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)			6			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					47,304	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					47,304	23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N	25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N	27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	28.00	
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility					N	N	N
30.00	Nursing Facility							
31.00	ICF/IID							
32.00	SNF-Based HHA					N	N	
33.00	SNF-Based RHC							
34.00	SNF-Based FQHC							
35.00	SNF-Based CMHC						N	
36.00	SNF-Based OLTC							
				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. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 1:32 pm
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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. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 1:32 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	04/26/2024	Y	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

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

Provider No. : 315362

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/24/2024 1:32 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ALEXANDER	SOCHACKI	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	AL.SOCHACKI@HCRNJ.NET	21.00

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

Provider No. : 315362

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/24/2024 1:32 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	04/26/2024	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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. : 315362

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/24/2024 1:32 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	94	34,310	0	4,107	21,051	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	94	34,310	0	4,107	21,051	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	6,517	31,675	0	101	79	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	6,517	31,675	0	101	79	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	124	304	0.00	40.66	266.47	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	124	304	0.00	40.66	266.47	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX		Other
		16.00	17.00	18.00	19.00		20.00
1.00	SKILLED NURSING FACILITY	104.19	0	137	43	117	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	104.19	0	137	43	117	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	297	85.00	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	297	85.00	0.00	8.00		

Provider No. : 315362

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2024 1:32 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	4,816,525	0	4,816,525	176,646.00	27.27
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	4,816,525	0	4,816,525	176,646.00	27.27
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00
9.00	CMHC	0	0	0	0.00	0.00
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	4,816,525	0	4,816,525	176,646.00	27.27
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	811,190	0	811,190	14,994.00	54.10
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
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	581,158	0	581,158		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	581,158	0	581,158		

Provider No. : 315362

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2024 1:32 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	414,041	0	414,041	10,629.00	2.00
3.00	Plant Operation, Maintenance & Repairs	67,990	0	67,990	2,064.00	3.00
4.00	Laundry & Linen Service	58,902	0	58,902	3,242.00	4.00
5.00	Housekeeping	176,292	0	176,292	10,941.00	5.00
6.00	Dietary	412,964	0	412,964	22,187.00	6.00
7.00	Nursing Administration	289,799	0	289,799	12,691.00	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	40,250	0	40,250	2,096.00	10.00
11.00	Social Service	86,399	0	86,399	2,516.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	103,059	0	103,059	5,802.00	13.00
14.00	Total (sum lines 1 thru 13)	1,649,696	0	1,649,696	72,168.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2024 1:32 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	7,110	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	82,778	8.00
9.00	Prescription Drug Plan	457	9.00
10.00	Dental, Hearing and Vision Plan	7,893	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,065	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	75,330	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	370,338	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	36,187	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	581,158	24.00
		Amount Reported	
		1.00	
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315362

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

Worksheet S-3
Part V
Date/Time Prepared:
5/24/2024 1:32 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	638,005	81,282	719,287	11,178.00	64.35	1.00
2.00	Licensed Practical Nurses (LPNs)	1,048,521	133,582	1,182,103	27,766.00	42.57	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,480,303	188,591	1,668,894	65,534.00	25.47	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,166,829	403,455	3,570,284	104,478.00	34.17	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	2,296		2,296	38.00	60.42	14.00
15.00	Licensed Practical Nurses (LPNs)	140,413		140,413	2,693.00	52.14	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	64,104		64,104	2,205.00	29.07	16.00
17.00	Total Nursing (sum of lines 14 through 16)	206,813		206,813	4,936.00	41.90	17.00
18.00	Physical Therapists	67,432		67,432	1,289.00	52.31	18.00
19.00	Physical Therapy Assistants	200,174		200,174	3,826.00	52.32	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	144,163		144,163	2,178.00	66.19	21.00
22.00	Occupational Therapy Assistants	80,797		80,797	1,221.00	66.17	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	111,810		111,810	1,543.00	72.46	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. : 315362

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

Worksheet S-7
Date/Time Prepared:
5/24/2024 1:32 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315362

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

Worksheet S-7

Date/Time Prepared:
5/24/2024 1:32 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/24/2024 1:32 pm	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)
	1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES		1,510,861	0	1,510,861
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0	0	0
3.00 00300	EMPLOYEE BENEFITS	0	613,460	0	613,460
4.00 00400	ADMINISTRATIVE & GENERAL	414,041	1,925,312	0	2,339,353
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	67,990	284,137	0	352,127
6.00 00600	LAUNDRY & LINEN SERVICE	58,902	44,613	0	103,515
7.00 00700	HOUSEKEEPING	176,292	65,531	0	241,823
8.00 00800	DIETARY	412,964	430,793	0	843,757
9.00 00900	NURSING ADMINISTRATION	289,799	0	0	289,799
10.00 01000	CENTRAL SERVICES & SUPPLY	0	155,103	0	155,103
11.00 01100	PHARMACY	0	0	0	0
12.00 01200	MEDICAL RECORDS & LIBRARY	40,250	0	0	40,250
13.00 01300	SOCIAL SERVICE	86,399	900	0	87,299
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0
15.00 01500	PATIENT ACTIVITIES	103,059	31,674	0	134,733
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	SKILLED NURSING FACILITY	3,166,829	336,804	0	3,503,633
31.00 03100	NURSING FACILITY	0	0	0	0
32.00 03200	ICF/IID	0	0	0	0
33.00 03300	OTHER LONG TERM CARE	0	0	0	0
ANCILLARY SERVICE COST CENTERS					
40.00 04000	RADIOLOGY	0	7,783	0	7,783
41.00 04100	LABORATORY	0	18,855	0	18,855
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0
43.00 04300	OXYGEN (INHALATION) THERAPY	0	2,834	0	2,834
44.00 04400	PHYSICAL THERAPY	0	245,151	0	245,151
45.00 04500	OCCUPATIONAL THERAPY	0	206,921	0	206,921
46.00 04600	SPEECH PATHOLOGY	0	103,236	0	103,236
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
49.00 04900	DRUGS CHARGED TO PATIENTS	0	127,708	0	127,708
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0
51.00 05100	SUPPORT SURFACES	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
60.00 06000	CLINIC	0	0	0	0
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0
62.00 06200	FOHC	0	0	0	0
OTHER REIMBURSABLE COST CENTERS					
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0
71.00 07100	AMBULANCE	0	18,665	0	18,665
73.00 07300	CMHC	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0
81.00 08100	INTEREST EXPENSE	0	0	0	0
82.00 08200	UTILIZATION REVIEW - SNF	0	0	0	0
83.00 08300	HOSPICE	0	0	0	0
89.00	SUBTOTALS (sum of lines 1-84)	4,816,525	6,130,341	0	10,946,866
NONREIMBURSABLE COST CENTERS					
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0
91.00 09100	BARBER AND BEAUTY SHOP	0	2,447	0	2,447
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0
93.00 09300	NONPAID WORKERS	0	0	0	0
94.00 09400	PATIENTS LAUNDRY	0	0	0	0
100.00	TOTAL	4,816,525	6,132,788	0	10,949,313

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/24/2024 1:32 pm
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Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	241,456	1,752,317	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	613,460	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-512,183	1,827,170	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	352,127	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	103,515	6.00
7.00	00700	HOUSEKEEPING	0	241,823	7.00
8.00	00800	DIETARY	0	843,757	8.00
9.00	00900	NURSING ADMINISTRATION	0	289,799	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	155,103	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	40,250	12.00
13.00	01300	SOCIAL SERVICE	0	87,299	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	134,733	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	3,503,633	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	7,783	40.00
41.00	04100	LABORATORY	0	18,855	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	2,834	43.00
44.00	04400	PHYSICAL THERAPY	0	245,151	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	206,921	45.00
46.00	04600	SPEECH PATHOLOGY	0	103,236	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	127,708	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC			62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	18,665	71.00
73.00	07300	CMHC	0	0	73.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	-270,727	10,676,139	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	2,447	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	-270,727	10,678,586	100.00

Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/24/2024 1:32 pm
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		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Recl assi fi cations (Sum of col umns 4 and 5 must equal sum of col umns 8 and 9)				0	0 100.00

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

Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/24/2024 1:32 pm
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		Decreases			
		Cost Center	Line #	Salary	Non Salary
		6.00	7.00	8.00	9.00
100.00	TOTALS			0	0
					100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315362

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

Worksheet A-7

Date/Time Prepared:
5/24/2024 1:32 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	0	0	0	0	0	3.00
4.00 Building Improvements	43,999	145,948	0	145,948	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	119,219	4,226	0	4,226	0	6.00
7.00 Subtotal (sum of lines 1-6)	163,218	150,174	0	150,174	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	163,218	150,174	0	150,174	0	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
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	189,947	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	123,445	0				6.00
7.00 Subtotal (sum of lines 1-6)	313,392	0				7.00
8.00 Reconciling Items	0	0				8.00
9.00 Total (line 7 minus line 8)	313,392	0				9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315362

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

Worksheet A-8

Date/Time Prepared:
5/24/2024 1:32 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line No.	
			1.00	2.00	3.00	4.00
1.00 Investment income on restricted funds (chapter 2)	B	-9,538	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	50,097				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals		0			0.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-70	ADMINISTRATIVE & GENERAL		4.00	18.00
19.00 Vending machines		0			0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00	22.00
23.00 Depreciation--buildings and fixtures			CAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			CAP REL COSTS - MOVABLE EQUIPMENT		2.00	24.00
25.00 RESIDENT MISSING ITEMS	A	-195	ADMINISTRATIVE & GENERAL		4.00	25.00
25.01 FINES & PENALTIES	A	-100	ADMINISTRATIVE & GENERAL		4.00	25.01
25.02 MARKETING	A	-32,507	ADMINISTRATIVE & GENERAL		4.00	25.02
25.03 BAD DEBT	A	-218,570	ADMINISTRATIVE & GENERAL		4.00	25.03
25.04 MARKETING WAGES	A	-26,042	ADMINISTRATIVE & GENERAL		4.00	25.04
25.05 RESIDENT MISSING ITEMS	A	-1,500	ADMINISTRATIVE & GENERAL		4.00	25.05
25.06 FINES & PENALTIES	A	-32,302	ADMINISTRATIVE & GENERAL		4.00	25.06
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-270,727				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. : 315362

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

Worksheet A-8-1
Parts I-II
Date/Time Prepared:
5/24/2024 1:32 pm

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00	
2.00	4.00	ADMINISTRATIVE & GENERAL	REALTY A&G COSTS	2.00	
3.00	4.00	ADMINISTRATIVE & GENERAL	COMPLETE CARE MGMT	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	1,486,817	1,235,823	250,994	1.00	
2.00	21,741	0	21,741	2.00	
3.00	379,136	601,774	-222,638	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	
	1,887,694	1,837,597	50,097		

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/24/2024 1:32 pm
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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	PEACE CAP HOLDINGS	100.00	1.00
2.00	B	AURORA GUARDIAN HOLDCO II, LLC	0.00	2.00
3.00	B	PEACE CAPITAL	100.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00	AURORA GUARDIAN HOLDCO II, LLC	33.00	HOLDING COMPANY	1.00
2.00	PARK PLACE REALTY, LLC	100.00	REALTY	2.00
3.00	COMPLETE CARE MGMT	100.00	MANAGEMENT COMPANY	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. : 315362

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,752,317	1,752,317			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	613,460	0	0	613,460	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,827,170	254,640	0	52,735	2,134,545 4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	352,127	50,880	0	8,660	411,667 5.00
6.00 00600	LAUNDRY & LINEN SERVICE	103,515	49,218	0	7,502	160,235 6.00
7.00 00700	HOUSEKEEPING	241,823	23,629	0	22,454	287,906 7.00
8.00 00800	DIETARY	843,757	191,291	0	52,598	1,087,646 8.00
9.00 00900	NURSING ADMINISTRATION	289,799	36,572	0	36,911	363,282 9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	155,103	11,874	0	0	166,977 10.00
11.00 01100	PHARMACY	0	0	0	0	0 11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	40,250	0	0	5,126	45,376 12.00
13.00 01300	SOCIAL SERVICE	87,299	7,540	0	11,004	105,843 13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0 14.00
15.00 01500	PATIENT ACTIVITIES	134,733	0	0	13,126	147,859 15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	3,503,633	986,500	0	403,344	4,893,477 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	7,783	0	0	0	7,783 40.00
41.00 04100	LABORATORY	18,855	0	0	0	18,855 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	2,834	0	0	0	2,834 43.00
44.00 04400	PHYSICAL THERAPY	245,151	70,116	0	0	315,267 44.00
45.00 04500	OCCUPATIONAL THERAPY	206,921	65,842	0	0	272,763 45.00
46.00 04600	SPEECH PATHOLOGY	103,236	4,215	0	0	107,451 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	127,708	0	0	0	127,708 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FQHC	0	0	0	0	0 62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	18,665	0	0	0	18,665 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	10,676,139	1,752,317	0	613,460	10,676,139 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	2,447	0	0	0	2,447 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	10,678,586	1,752,317	0	613,460	10,678,586 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315362

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	2,134,545				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	102,846	514,513			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	40,031	17,503	217,769		6.00	
7.00	00700	HOUSEKEEPING	71,927	8,403	0	368,236	7.00	
8.00	00800	DIETARY	271,726	68,027	0	51,269	1,478,668	8.00
9.00	00900	NURSING ADMINISTRATION	90,758	13,006	0	9,802	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	41,716	4,223	0	3,182	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	11,336	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	26,443	2,681	0	2,021	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	36,939	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,222,530	350,821	217,769	264,394	1,478,668	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	1,944	0	0	0	0	40.00
41.00	04100	LABORATORY	4,711	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	708	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	78,763	24,935	0	18,792	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	68,144	23,415	0	17,646	0	45.00
46.00	04600	SPEECH PATHOLOGY	26,844	1,499	0	1,130	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	31,905	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	4,663	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	2,133,934	514,513	217,769	368,236	1,478,668	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	611	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	2,134,545	514,513	217,769	368,236	1,478,668	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315362

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	476,848					9.00
10.00	01000	0	216,098				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	56,712		12.00
13.00	01300	0	0	0	0	136,988	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	476,848	118,515	0	56,712	136,988	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	97,583	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		476,848	216,098	0	56,712	136,988	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00	TOTAL	476,848	216,098	0	56,712	136,988	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315362

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		PATIENT ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	184,798			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	184,798	9,401,520	0	9,401,520 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	9,727	0	9,727 40.00
41.00 04100	LABORATORY	0	0	23,566	0	23,566 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	3,542	0	3,542 43.00
44.00 04400	PHYSICAL THERAPY	0	0	437,757	0	437,757 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	381,968	0	381,968 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	136,924	0	136,924 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	257,196	0	257,196 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	23,328	0	23,328 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	184,798	10,675,528	0	10,675,528 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	3,058	0	3,058 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	184,798	10,678,586	0	10,678,586 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315362

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	254,640	0	254,640	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	50,880	0	50,880	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	49,218	0	49,218	6.00
7.00 00700	HOUSEKEEPING	0	23,629	0	23,629	7.00
8.00 00800	DIETARY	0	191,291	0	191,291	8.00
9.00 00900	NURSING ADMINISTRATION	0	36,572	0	36,572	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	11,874	0	11,874	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	7,540	0	7,540	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	986,500	0	986,500	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	70,116	0	70,116	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	65,842	0	65,842	45.00
46.00 04600	SPEECH PATHOLOGY	0	4,215	0	4,215	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1,752,317	0	1,752,317	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments				0	98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	1,752,317	0	1,752,317	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315362		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/24/2024 1:32 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL	254,640				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	12,269	63,149			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	4,775	2,148	56,141		6.00
7.00	00700	HOUSEKEEPING	8,580	1,031	0	33,240	7.00
8.00	00800	DIETARY	32,415	8,349	0	4,628	236,683
9.00	00900	NURSING ADMINISTRATION	10,827	1,596	0	885	0
10.00	01000	CENTRAL SERVICES & SUPPLY	4,976	518	0	287	0
11.00	01100	PHARMACY	0	0	0	0	0
12.00	01200	MEDICAL RECORDS & LIBRARY	1,352	0	0	0	0
13.00	01300	SOCIAL SERVICE	3,154	329	0	182	0
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0
15.00	01500	PATIENT ACTIVITIES	4,407	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	145,845	43,060	56,141	23,867	236,683
31.00	03100	NURSING FACILITY	0	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	232	0	0	0	0
41.00	04100	LABORATORY	562	0	0	0	0
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	84	0	0	0	0
44.00	04400	PHYSICAL THERAPY	9,396	3,060	0	1,696	0
45.00	04500	OCCUPATIONAL THERAPY	8,129	2,874	0	1,593	0
46.00	04600	SPEECH PATHOLOGY	3,202	184	0	102	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	3,806	0	0	0	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	0
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00	06200	FOHC	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00	07100	AMBULANCE	556	0	0	0	0
73.00	07300	CMHC	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	254,567	63,149	56,141	33,240	236,683
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	73	0	0	0	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0
98.00		Cross Foot Adjustments					0
99.00		Negative Cost Centers	0	0	0	0	0
100.00		TOTAL	254,640	63,149	56,141	33,240	236,683

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315362

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	49,880					9.00
10.00	01000	0	17,655				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	1,352		12.00
13.00	01300	0	0	0	0	11,205	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	49,880	9,683	0	1,352	11,205	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	7,972	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		49,880	17,655	0	1,352	11,205	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		49,880	17,655	0	1,352	11,205	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315362

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	Post Step-Down Adjustments	Total	
		14.00 15.00 16.00 17.00 18.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	4,407			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	4,407	1,568,623	0	1,568,623 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	232	0	232 40.00
41.00 04100	LABORATORY	0	0	562	0	562 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	84	0	84 43.00
44.00 04400	PHYSICAL THERAPY	0	0	84,268	0	84,268 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	78,438	0	78,438 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	7,703	0	7,703 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	11,778	0	11,778 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	556	0	556 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	4,407	1,752,244	0	1,752,244 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	73	0	73 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	4,407	1,752,317	0	1,752,317 100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315362

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

Worksheet B-1
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	29,515				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0			2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	4,816,525		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	4,289	0	414,041	-2,134,545	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	857	0	67,990	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	829	0	58,902	0	6.00
7.00 00700	HOUSEKEEPING	398	0	176,292	0	7.00
8.00 00800	DIETARY	3,222	0	412,964	0	8.00
9.00 00900	NURSING ADMINISTRATION	616	0	289,799	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	200	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	40,250	0	12.00
13.00 01300	SOCIAL SERVICE	127	0	86,399	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	0	0	103,059	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	16,616	0	3,166,829	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	1,181	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	1,109	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	71	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	29,515	0	4,816,525	-2,134,545	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1,752,317	0	613,460	2,134,545	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	59.370388	0.000000	0.127366	0.249829	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0	254,640	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.029803	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315362

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500	24,369					5.00
6.00	00600	829	31,675				6.00
7.00	00700	398	0	23,142			7.00
8.00	00800	3,222	0	3,222	95,025		8.00
9.00	00900	616	0	616	0	109,414	9.00
10.00	01000	200	0	200	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	127	0	127	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	16,616	31,675	16,616	95,025	109,414	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,181	0	1,181	0	0	44.00
45.00	04500	1,109	0	1,109	0	0	45.00
46.00	04600	71	0	71	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		24,369	31,675	23,142	95,025	109,414	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		514,513	217,769	368,236	1,478,668	476,848	102.00
103.00		21.113423	6.875107	15.912021	15.560831	4.358199	103.00
104.00		63,149	56,141	33,240	236,683	49,880	104.00
105.00		2.591366	1.772407	1.436349	2.490745	0.455883	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315362

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

Worksheet B-1
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)		
		10.00	11.00	12.00	13.00	14.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
3.00	00300						3.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	282,811					10.00	
11.00	01100	0	0				11.00	
12.00	01200	0	0	31,675			12.00	
13.00	01300	0	0	0	31,675		13.00	
14.00	01400	0	0	0	0	0	14.00	
15.00	01500	0	0	0	0	0	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	155,103	0	31,675	31,675	0	30.00	
31.00	03100	0	0	0	0	0	31.00	
32.00	03200	0	0	0	0	0	32.00	
33.00	03300	0	0	0	0	0	33.00	
ANCILLARY SERVICE COST CENTERS								
40.00	04000	0	0	0	0	0	40.00	
41.00	04100	0	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	0	0	0	0	0	43.00	
44.00	04400	0	0	0	0	0	44.00	
45.00	04500	0	0	0	0	0	45.00	
46.00	04600	0	0	0	0	0	46.00	
47.00	04700	0	0	0	0	0	47.00	
48.00	04800	0	0	0	0	0	48.00	
49.00	04900	127,708	0	0	0	0	49.00	
50.00	05000	0	0	0	0	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
73.00	07300	0	0	0	0	0	73.00	
SPECIAL PURPOSE COST CENTERS								
80.00	08000						80.00	
81.00	08100						81.00	
82.00	08200						82.00	
83.00	08300	0	0	0	0	0	83.00	
89.00	SUBTOTALS (sum of lines 1-84)		282,811	0	31,675	31,675	0	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	09300	0	0	0	0	0	93.00	
94.00	09400	0	0	0	0	0	94.00	
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)		216,098	0	56,712	136,988	0	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)		0.764107	0.000000	1.790434	4.324799	0.000000	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		17,655	0	1,352	11,205	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.062427	0.000000	0.042684	0.353749	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315362

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description		OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT CENSUS)	
		15.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300 EMPLOYEE BENEFITS		3.00
4.00	00400 ADMINISTRATIVE & GENERAL		4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600 LAUNDRY & LINEN SERVICE		6.00
7.00	00700 HOUSEKEEPING		7.00
8.00	00800 DIETARY		8.00
9.00	00900 NURSING ADMINISTRATION		9.00
10.00	01000 CENTRAL SERVICES & SUPPLY		10.00
11.00	01100 PHARMACY		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY		12.00
13.00	01300 SOCIAL SERVICE		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500 PATIENT ACTIVITIES	31,675	15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 SKILLED NURSING FACILITY	31,675	30.00
31.00	03100 NURSING FACILITY	0	31.00
32.00	03200 ICF/IID	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	04000 RADIOLOGY	0	40.00
41.00	04100 LABORATORY	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400 PHYSICAL THERAPY	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100 SUPPORT SURFACES	0	51.00
OUTPATIENT SERVICE COST CENTERS			
60.00	06000 CLINIC	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	61.00
62.00	06200 FOHC	0	62.00
OTHER REIMBURSABLE COST CENTERS			
70.00	07000 HOME HEALTH AGENCY COST	0	70.00
71.00	07100 AMBULANCE	0	71.00
73.00	07300 CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100 INTEREST EXPENSE		81.00
82.00	08200 UTILIZATION REVIEW - SNF		82.00
83.00	08300 HOSPICE	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	31,675	89.00
NONREIMBURSABLE COST CENTERS			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300 NONPAID WORKERS	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	94.00
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)	184,798	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	5.834191	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	4,407	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.139132	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/24/2024 1:32 pm
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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	9,727	7,783	1.249775	40.00
41.00	04100	LABORATORY	23,566	18,855	1.249854	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	3,542	2,834	1.249824	43.00
44.00	04400	PHYSICAL THERAPY	437,757	417,464	1.048610	44.00
45.00	04500	OCCUPATIONAL THERAPY	381,968	366,441	1.042372	45.00
46.00	04600	SPEECH PATHOLOGY	136,924	228,406	0.599476	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	257,196	127,708	2.013938	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FQHC				62.00
71.00	07100	AMBULANCE	23,328	18,665	1.249826	71.00
100.00		Total	1,274,008	1,188,156		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/24/2024 1:32 pm
		Title XVIII (1)	Skilled Nursing Facility	PPS

	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost		
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1.00	2.00	3.00	4.00	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST						
ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADIOLOGY	1.249775	0	0	0	0 40.00
41.00	04100 LABORATORY	1.249854	3,644	0	4,554	0 41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0 42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1.249824	0	0	0	0 43.00
44.00	04400 PHYSICAL THERAPY	1.048610	152,289	0	159,692	0 44.00
45.00	04500 OCCUPATIONAL THERAPY	1.042372	137,928	0	143,772	0 45.00
46.00	04600 SPEECH PATHOLOGY	0.599476	100,997	0	60,545	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	2.013938	69,863	0	140,700	0 49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0 50.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0.000000	0	0	0	0 60.00
61.00	06100 RURAL HEALTH CLINIC					61.00
62.00	06200 FQHC					62.00
71.00	07100 AMBULANCE (2)	1.249826		0		0 71.00
100.00	Total (Sum of lines 40 - 71)		464,721	0	509,263	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. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/24/2024 1:32 pm				
		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)		2.013938	1.00			
2.00		Program vaccine charges (From your records, or the PS&R)		1,853	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)		3,732	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	9,727	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	23,566	0	0.000000	4,554	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	3,542	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	437,757	0	0.000000	159,692	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	381,968	0	0.000000	143,772	0	45.00
46.00	04600	SPEECH PATHOLOGY	136,924	0	0.000000	60,545	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	257,196	0	0.000000	140,700	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	1,250,680	0		509,263	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/24/2024 1:32 pm
	Title XVIII	Skilled Nursing Facility	PPS

	1.00	
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PART I CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1.00	Inpatient days including private room days	31,675	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	4,107	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	9,401,520	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	11,890,417	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.790680	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	9,401,520	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	296.81	16.00
17.00	Program routine service cost (Line 3 times line 16)	1,218,999	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	1,218,999	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)	1,568,623	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	49.52	21.00
22.00	Program capital related cost (Line 3 times line 21)	203,379	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,015,620	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,015,620	25.00
26.00	Enter the per diem limitation (1)		26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00

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

	1.00	
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PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days	31,675	1.00
2.00	Program inpatient days (see instructions)	4,107	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)	0.129661	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. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/24/2024 1:32 pm
		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)		3,105,664	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)		3,105,664	3.00
4.00	Primary payor amounts		16,200	4.00
5.00	Coinurance		491,400	5.00
6.00	Allowable bad debts (From your records)		270,290	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		155,024	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		175,689	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)		2,773,753	11.00
12.00	Interim payments (See instructions)		2,589,594	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)		3,514	14.75
14.99	Sequestration amount (see instructions)		51,961	14.99
15.00	Balance due provider/program (see Instructions)		128,684	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)		3,732	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		3,732	19.00
20.00	Medicare Part B ancillary charges (See instructions)		1,853	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		1,853	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinurance 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)		1,853	25.00
26.00	Interim payments (See instructions)		1,126	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)		37	28.99
29.00	Balance due provider/program (see instructions)		690	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315362	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part II Date/Time Prepared: 5/24/2024 1:32 pm
		Title XIX	Skilled Nursing Facility	PPS
				1.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		0	4.00
5.00	Utilization review--physicians' compensation (from provider records)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)		0	6.00
7.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		0	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		0	10.00
REASONABLE CHARGES				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315362

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

Worksheet E-1

Date/Time Prepared:
5/24/2024 1:32 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		2,570,655		1,126	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/23/2023	18,939		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)		18,939		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)		2,589,594		1,126	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		128,684		690	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,718,278		1,816	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. : 315362

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

Worksheet G

Date/Time Prepared:
5/24/2024 1:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	83,387	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	4,207,355	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-248,506	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	40,561	0	0	0	8.00
9.00	Other current assets	7,800	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4,090,597	0	0	0	11.00
FIXED ASSETS						
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	189,946	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	123,444	0	0	0	23.00
24.00	Less: Accumulated depreciation	-75,039	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	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	238,351	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	363,957	0	0	0	31.00
32.00	Other assets	48,406	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	412,363	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	4,741,311	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	907,010	0	0	0	35.00
36.00	Salaries, wages, and fees payable	464,375	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	636,958	0	0	0	38.00
39.00	Deferred income	377,768	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2,386,111	0	0	0	43.00
LONG TERM LIABILITIES						
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	-631,413	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	-631,413	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	1,754,698	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,986,613	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	2,986,613	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	4,741,311	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315362

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

Worksheet G-1

Date/Time Prepared:
5/24/2024 1:32 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		1,900,443		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		1,086,171			2.00
3.00	Total (sum of line 1 and line 2)		2,986,614		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		2,986,614		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00	ROUNDING	1		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		1		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		2,986,613		0	19.00
		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)					4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 5 - 9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)					12.00
13.00	ROUNDING		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. : 315362

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/24/2024 1:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	11,890,417		11,890,417	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	11,890,417		11,890,417	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,188,157	0	1,188,157	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	337	0	337	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	13,078,911	0	13,078,911	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			10,949,313	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			10,949,313	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315362

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

Worksheet G-3

Date/Time Prepared:
5/24/2024 1:32 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	13,078,911	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,059,347	2.00
3.00	Net patient revenues (Line 1 minus line 2)	12,019,564	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	10,949,313	4.00
5.00	Net income from service to patients (Line 3 minus 4)	1,070,251	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	9,538	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	70	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	5,055	24.00
24.01	BARBER BEAUTY	1,257	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	15,920	25.00
26.00	Total (Line 5 plus line 25)	1,086,171	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)	1,086,171	31.00