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: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 8/23/2024 11:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/23/2024 Time: 11:45 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
3.01 [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no.

Contractor use only

4. [1] 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. [N] First Cost Report for this Provider CCN
8. [N] Last Cost Report for this Provider CCN
9. NPR Date: _____
10. [0] If line 4, column 1 is "4": Enter number of times reopened
11. Contractor Vendor Code _____4
12. [F] 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 LITTLE BROOK NURSING & CONV. HOME (315467) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	John Hampilos		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	John Hampilos			2
3	Signatory Title	MANAGING DIRECTOR			3
4	Date	(Dated when report is electronica			4

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

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

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

Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/23/2024 11:45 pm

	1.00	2.00	3.00	
	Skilled Nursing Facility and Skilled Nursing Facility Complex Address:			
1.00	Street: 78 SLIKER ROAD	PO Box:		1.00
2.00	City: CALIFON	State: NJ	Zip Code: 07830	2.00
3.00	County: HUNTERDON	CBSA Code: 35084	Urban/Rural: U	3.00
3.01		CBSA Code:		3.01

		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
					V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:							
4.00	SNF	LITTLE BROOK NURSING & CONV. HOME	315467	02/01/2001	N	P	O	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00

		From:	To:	
		1.00	2.00	
14.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	14.00
15.00	Type of Control (See Instructions)	4		15.00

		Y/N	
		1.00	
	Type of Freestanding Skilled Nursing Facility		
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.	Y	18.00
	Miscellaneous Cost Reporting Information		
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.01
	Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.		
20.00	Straight Line	17,599	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	17,599	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		29.00
30.00	Nursing Facility			N	30.00
31.00	ICF/IID				31.00
32.00	SNF-Based HHA	N	N		32.00
33.00	SNF-Based RHC				33.00
34.00	SNF-Based FQHC		N		34.00
35.00	SNF-Based CMHC		N		35.00
36.00	SNF-Based OLTC				36.00

		Y/N		
		1.00	2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)	Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)	N		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.			39.00

		Premiums	Paid Losses	Self Insurance	
		1.00	2.00	3.00	
41.00	List malpractice premiums and paid losses:	0	0	0	41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX INDENTIFICATION DATA	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/23/2024 11:45 pm

		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	N	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.		44.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter the name and address of the home office on the lines below.			
45.00	Name:	Contractor's Name:	Contractor's Number:	45.00
46.00	Street:	PO Box:		46.00
47.00	City:	State:	Zip Code:	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/23/2024 11:45 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 Facilites			
	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.	N	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	08/22/2024	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.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 8/23/2024 11:45 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.	VARIOUS	VARIOUS	19.00
20.00	Enter the employer/company name of the cost report preparer.	HUBCO HEALTH CARE GROUP, LLC		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6097301980	COSTREPORTS@HUBCO.NET	21.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 8/23/2024 11:45 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.)	08/22/2024			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.		VARIOUS		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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/23/2024 11:45 pm

	Component	Number of Beds	Bed Days Available	Inpatient Days/Visits: Title V	Inpatient Days/Visits: Title XVIII	Inpatient Days/Visits: Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	36	13,140	0	209	7,875	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	36	13,140	0	209	7,875	8.00

	Component	Inpatient Days/Visits: Other	Inpatient Days/Visits: Total	Discharges: Title V	Discharges: Title XVIII	Discharges: Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	2,293	10,377	0	7	8	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST	0	0				4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	2,293	10,377	0	7	8	8.00

	Component	Discharges: Other	Discharges: Total	Average Length of Stay: Title V	Average Length of Stay: Title XVIII	Average Length of Stay: Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	8	23	0.00	29.86	984.38	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	8	23	0.00	29.86	984.38	8.00

	Component	Average Length of Stay: Total	Admissions: Title V	Admissions: Title XVIII	Admissions: Title XIX	Admissions: Other	
		16.00	17.00	18.00	19.00	20.00	
1.00	SKILLED NURSING FACILITY	451.17	0	1	2	14	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID						3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE						7.00
8.00	Total (Sum of lines 1-7)	451.17	0	1	2	14	8.00

	Component	Admissions: Total	Full Time Equivalent: Employees on Payroll	Full Time Equivalent: Nonpaid Workers	
		21.00	22.00	23.00	
1.00	SKILLED NURSING FACILITY	17	26.45	0.00	1.00
2.00	NURSING FACILITY	0	0.00	0.00	2.00
3.00	ICF/IID				3.00
4.00	HOME HEALTH AGENCY COST		0.00	0.00	4.00
5.00	Other Long Term Care	0	0.00	0.00	5.00
6.00	SNF-Based CMHC		0.00	0.00	6.00
7.00	HOSPICE				7.00
8.00	Total (Sum of lines 1-7)	17	26.45	0.00	8.00

SNF WAGE INDEX INFORMATION | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 8/23/2024 11:45 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)	1,855,362	0	1,855,362	55,027.00	33.72	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	1,855,362	0	1,855,362	55,027.00	33.72	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
10.00	HOSPICE						10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	1,855,362	0	1,855,362	55,027.00	33.72	13.00
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	34,554	0	34,554	879.00	39.31	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	355,741	0	355,741			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	355,741	0	355,741			22.00

SNF WAGE INDEX INFORMATION | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 8/23/2024 11:45 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	0.00	0.00	1.00
2.00	Administrative & General	254,403	0	254,403	6,145.00	41.40	2.00
3.00	Plant Operation, Maintenance & Repairs	52,921	0	52,921	1,900.00	27.85	3.00
4.00	Laundry & Linen Service	18,795	0	18,795	1,314.00	14.30	4.00
5.00	Housekeeping	69,711	0	69,711	3,423.00	20.37	5.00
6.00	Dietary	157,507	0	157,507	6,652.00	23.68	6.00
7.00	Nursing Administration	123,114	0	123,114	1,893.00	65.04	7.00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	52,868	0	52,868	1,541.00	34.31	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	66,194	0	66,194	2,325.00	28.47	13.00
14.00	Total (sum lines 1 thru 13)	795,513	0	795,513	25,193.00	31.58	14.00

SNF WAGE RELATED COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 8/23/2024 11:45 pm

		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	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	77,436	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7,840	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	113,896	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	156,569	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	0	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)	355,741	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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 8/23/2024 11:45 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)	91,060	17,460	108,520	2,007.00	54.07	1.00
2.00	Licensed Practical Nurses (LPNs)	482,197	92,455	574,652	11,466.00	50.12	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	424,836	81,457	506,293	15,340.00	33.00	3.00
4.00	Total Nursing (sum of lines 1 through 3)	998,093	191,372	1,189,465	28,813.00	41.28	4.00
5.00	Physical Therapists	39,551	7,583	47,134	644.00	73.19	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	15,791	3,028	18,819	271.00	69.44	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	6,414	1,230	7,644	106.00	72.11	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	15,584		15,584	311.00	50.11	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	18,970		18,970	568.00	33.40	16.00
17.00	Total Nursing (sum of lines 14 through 16)	34,554		34,554	879.00	39.31	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-7 | Date/Time Prepared: 8/23/2024 11:45 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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-7 | Date/Time Prepared: 8/23/2024 11:45 pm

		Group	Days	
		1.00	2.00	
76.00		PA1		76.00
99.00		AAA		99.00
100.00	TOTAL			100.00

		Expenses	Percentage	Y/N	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)				
101.00	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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 8/23/2024 11:45 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		286,357	286,357	0	286,357	1.00
3.00	00300	EMPLOYEE BENEFITS	0	355,741	355,741	0	355,741	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	254,403	526,731	781,134	0	781,134	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	52,921	104,363	157,284	0	157,284	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	18,795	6,962	25,757	0	25,757	6.00
7.00	00700	HOUSEKEEPING	69,711	18,991	88,702	0	88,702	7.00
8.00	00800	DIETARY	157,507	115,959	273,466	0	273,466	8.00
9.00	00900	NURSING ADMINISTRATION	123,114	0	123,114	0	123,114	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	70,752	70,752	0	70,752	10.00
11.00	01100	PHARMACY	0	11,234	11,234	0	11,234	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	52,868	0	52,868	0	52,868	13.00
15.00	01500	PATIENT ACTIVITIES	66,194	16,562	82,756	0	82,756	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	998,093	149,407	1,147,500	0	1,147,500	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	3,472	3,472	0	3,472	40.00
41.00	04100	LABORATORY	0	114	114	0	114	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	5,402	5,402	0	5,402	43.00
44.00	04400	PHYSICAL THERAPY	39,551	0	39,551	0	39,551	44.00
45.00	04500	OCCUPATIONAL THERAPY	15,791	0	15,791	0	15,791	45.00
46.00	04600	SPEECH PATHOLOGY	6,414	0	6,414	0	6,414	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	10,859	10,859	0	10,859	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	1,855,362	1,682,906	3,538,268	0	3,538,268	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	1,283	1,283	0	1,283	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
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
100.00		TOTAL	1,855,362	1,684,189	3,539,551	0	3,539,551	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 8/23/2024 11:45 pm

		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	-161,215	125,142		1.00
3.00	00300	EMPLOYEE BENEFITS	0	355,741		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-16,432	764,702		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	157,284		5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	25,757		6.00
7.00	00700	HOUSEKEEPING	0	88,702		7.00
8.00	00800	DIETARY	0	273,466		8.00
9.00	00900	NURSING ADMINISTRATION	0	123,114		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	70,752		10.00
11.00	01100	PHARMACY	0	11,234		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0		12.00
13.00	01300	SOCIAL SERVICE	0	52,868		13.00
15.00	01500	PATIENT ACTIVITIES	0	82,756		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	1,147,500		30.00
31.00	03100	NURSING FACILITY	0	0		31.00
33.00	03300	OTHER LONG TERM CARE	0	0		33.00
		ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	3,472		40.00
41.00	04100	LABORATORY	0	114		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	5,402		43.00
44.00	04400	PHYSICAL THERAPY	0	39,551		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	15,791		45.00
46.00	04600	SPEECH PATHOLOGY	0	6,414		46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	10,859		49.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
		OUTPATIENT SERVICE COST CENTERS				
62.00	06200	FQHC				62.00
		OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	0		70.00
71.00	07100	AMBULANCE	0	0		71.00
73.00	07300	CMHC	0	0		73.00
		SPECIAL PURPOSE COST CENTERS				
89.00		SUBTOTALS (sum of lines 1-84)	-177,647	3,360,621		89.00
		NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100	BARBER & BEAUTY SHOP	0	1,283		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
95.00	09500	OTHER NONREIMBURSABLE COST	0	0		95.00
100.00		TOTAL	-177,647	3,361,904		100.00

RECLASSIFICATIONS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/23/2024 11:45 pm

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

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

RECLASSIFICATIONS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/23/2024 11:45 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	TOTALS					
100.00				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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 | Date/Time Prepared: 8/23/2024 11:45 pm

	Description	Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		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	315,307	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	424,222	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	739,529	0	0	0	0	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	739,529	0	0	0	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	315,307	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	424,222	0	6.00
7.00	Subtotal (sum of lines 1-6)	739,529	0	7.00
8.00	Reconciling Items	0	0	8.00
9.00	Total (line 7 minus line 8)	739,529	0	9.00

ADJUSTMENTS TO EXPENSES | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 8/23/2024 11:45 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	0	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	-161,215			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals		0		0.00	14.00
15.00	Cost of meals - Guests		0		0.00	15.00
16.00	Sale of medical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Vending machines		0		0.00	19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	82.00	22.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00	Depreciation--movable equipment		0	*** Cost Center Deleted ***	2.00	24.00
25.00	TRANSPORTATION	A	-11,200	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01	MISC INCOME	B	-5,232	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02			0		0.00	25.02
25.03			0		0.00	25.03
25.04			0		0.00	25.04
25.05			0		0.00	25.05
25.06			0		0.00	25.06
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-177,647			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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 Parts I-II | Date/Time Prepared: 8/23/2024 11:45 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	DEPR/AMORT/INTEREST/TAXES	1.00
2.00		4.00	ADMINISTRATIVE & GENERAL	GENERAL MANAGEMENT CONSULT	2.00
3.00		4.00	ADMINISTRATIVE & GENERAL	ASSISTANT ADMINISTRATOR	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		78,785	240,000	-161,215		1.00
2.00		115,000	115,000	0		2.00
3.00		40,385	40,385	0		3.00
4.00		0	0	0		4.00
5.00		0	0	0		5.00
6.00		0	0	0		6.00
7.00		0	0	0		7.00
8.00		0	0	0		8.00
9.00		0	0	0		9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	234,170	395,385	-161,215		10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-II Date/Time Prepared: 8/23/2024 11:45 pm

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
1.00		B		0.00		1.00
2.00		B		0.00		2.00
3.00		E	JP HAMPILOS	49.00		3.00
4.00		E	ROSE MARY FERNANDEZ	51.00		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

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) 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:				
1.00		BETHANE PROPERTIES, INC.	0.00	REAL ESTATE	1.00
2.00		LAZARE GROUP, INC.	0.00	CONSULTING	2.00
3.00			49.00		3.00
4.00			51.00		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

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) 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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDGS & FIXTURES	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	3.00	3A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	125,142	125,142				1.00
3.00	00300	EMPLOYEE BENEFITS	355,741	0	355,741			3.00
4.00	00400	ADMINISTRATIVE & GENERAL	764,702	2,086	48,778	815,566	815,566	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	157,284	834	10,147	168,265	53,894	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	25,757	3,337	3,604	32,698	10,473	6.00
7.00	00700	HOUSEKEEPING	88,702	834	13,366	102,902	32,958	7.00
8.00	00800	DIETARY	273,466	5,006	30,200	308,672	98,865	8.00
9.00	00900	NURSING ADMINISTRATION	123,114	2,086	23,606	148,806	47,661	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	70,752	834	0	71,586	22,928	10.00
11.00	01100	PHARMACY	11,234	0	0	11,234	3,598	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	834	0	834	267	12.00
13.00	01300	SOCIAL SERVICE	52,868	0	10,137	63,005	20,180	13.00
15.00	01500	PATIENT ACTIVITIES	82,756	0	12,692	95,448	30,571	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	1,147,500	102,617	191,370	1,441,487	461,693	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	3,472	0	0	3,472	1,112	40.00
41.00	04100	LABORATORY	114	0	0	114	37	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	5,402	0	0	5,402	1,730	43.00
44.00	04400	PHYSICAL THERAPY	39,551	6,674	7,583	53,808	17,234	44.00
45.00	04500	OCCUPATIONAL THERAPY	15,791	0	3,028	18,819	6,028	45.00
46.00	04600	SPEECH PATHOLOGY	6,414	0	1,230	7,644	2,448	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	10,859	0	0	10,859	3,478	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	3,360,621	125,142	355,741	3,360,621	815,155	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	1,283	0	0	1,283	411	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
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
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	3,361,904	125,142	355,741	3,361,904	815,566	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS						3.00
4.00	00400	ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	222,159					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6,066	49,237				6.00
7.00	00700	HOUSEKEEPING	1,516	0	137,376			7.00
8.00	00800	DIETARY	9,099	0	5,825	422,461		8.00
9.00	00900	NURSING ADMINISTRATION	3,791	0	2,427	0	202,685	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	1,516	0	971	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	1,516	0	971	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	186,523	49,237	119,415	422,461	202,685	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	12,132	0	7,767	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	222,159	49,237	137,376	422,461	202,685	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
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	222,159	49,237	137,376	422,461	202,685	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	
			10.00	11.00	12.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS						3.00
4.00	00400	ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600	LAUNDRY & LINEN SERVICE						6.00
7.00	00700	HOUSEKEEPING						7.00
8.00	00800	DIETARY						8.00
9.00	00900	NURSING ADMINISTRATION						9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	97,001					10.00
11.00	01100	PHARMACY	0	14,832				11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	3,588			12.00
13.00	01300	SOCIAL SERVICE	0	0	0	83,185		13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	126,019	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	97,001	14,832	3,588	83,185	126,019	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	97,001	14,832	3,588	83,185	126,019	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0				0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	97,001	14,832	3,588	83,185	126,019	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	Subtotal	Post Stepdown Adjustments	Total		
			16.00	17.00	18.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE					6.00
7.00	00700	HOUSEKEEPING					7.00
8.00	00800	DIETARY					8.00
9.00	00900	NURSING ADMINISTRATION					9.00
10.00	01000	CENTRAL SERVICES & SUPPLY					10.00
11.00	01100	PHARMACY					11.00
12.00	01200	MEDICAL RECORDS & LIBRARY					12.00
13.00	01300	SOCIAL SERVICE					13.00
15.00	01500	PATIENT ACTIVITIES					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	3,208,126	0	3,208,126		30.00
31.00	03100	NURSING FACILITY	0	0	0		31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	4,584	0	4,584		40.00
41.00	04100	LABORATORY	151	0	151		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	7,132	0	7,132		43.00
44.00	04400	PHYSICAL THERAPY	90,941	0	90,941		44.00
45.00	04500	OCCUPATIONAL THERAPY	24,847	0	24,847		45.00
46.00	04600	SPEECH PATHOLOGY	10,092	0	10,092		46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	14,337	0	14,337		49.00
51.00	05100	SUPPORT SURFACES	0	0	0		51.00
		OUTPATIENT SERVICE COST CENTERS					
62.00	06200	FQHC					62.00
		OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	0		70.00
71.00	07100	AMBULANCE	0	0	0		71.00
73.00	07300	CMHC	0	0	0		73.00
		SPECIAL PURPOSE COST CENTERS					
89.00		SUBTOTALS (sum of lines 1-84)	3,360,210	0	3,360,210		89.00
		NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90.00
91.00	09100	BARBER & BEAUTY SHOP	1,694	0	1,694		91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0	0		93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0		94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0		95.00
98.00		Cross Foot Adjustments	0	0	0		98.00
99.00		Negative Cost Centers	0	0	0		99.00
100.00		TOTAL	3,361,904	0	3,361,904		100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	3.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS	0	0	0	0		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	2,086	2,086	0	2,086	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	834	834	0	138	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	3,337	3,337	0	27	6.00
7.00	00700	HOUSEKEEPING	0	834	834	0	84	7.00
8.00	00800	DIETARY	0	5,006	5,006	0	253	8.00
9.00	00900	NURSING ADMINISTRATION	0	2,086	2,086	0	122	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	834	834	0	59	10.00
11.00	01100	PHARMACY	0	0	0	0	9	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	834	834	0	1	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	52	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	78	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	0	102,617	102,617	0	1,181	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	3	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	4	43.00
44.00	04400	PHYSICAL THERAPY	0	6,674	6,674	0	44	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	15	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	6	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	9	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	0	125,142	125,142	0	2,085	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	1	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
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments			0			98.00
99.00		Negative Cost Centers		0	0	0	0	99.00
100.00		TOTAL	0	125,142	125,142	0	2,086	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS						3.00
4.00	00400	ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	972					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	27	3,391				6.00
7.00	00700	HOUSEKEEPING	7	0	925			7.00
8.00	00800	DIETARY	40	0	39	5,338		8.00
9.00	00900	NURSING ADMINISTRATION	17	0	16	0	2,241	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	7	0	7	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	7	0	7	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	814	3,391	804	5,338	2,241	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	53	0	52	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	972	3,391	925	5,338	2,241	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments		0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	972	3,391	925	5,338	2,241	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	
			10.00	11.00	12.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS						3.00
4.00	00400	ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600	LAUNDRY & LINEN SERVICE						6.00
7.00	00700	HOUSEKEEPING						7.00
8.00	00800	DIETARY						8.00
9.00	00900	NURSING ADMINISTRATION						9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	907					10.00
11.00	01100	PHARMACY	0	9				11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	849			12.00
13.00	01300	SOCIAL SERVICE	0	0	0	52		13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	78	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	907	9	849	52	78	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	907	9	849	52	78	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0			0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	907	9	849	52	78	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	Subtotal	Post Step-Down Adjustments	Total		
			16.00	17.00	18.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE					6.00
7.00	00700	HOUSEKEEPING					7.00
8.00	00800	DIETARY					8.00
9.00	00900	NURSING ADMINISTRATION					9.00
10.00	01000	CENTRAL SERVICES & SUPPLY					10.00
11.00	01100	PHARMACY					11.00
12.00	01200	MEDICAL RECORDS & LIBRARY					12.00
13.00	01300	SOCIAL SERVICE					13.00
15.00	01500	PATIENT ACTIVITIES					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	118,281	0	118,281		30.00
31.00	03100	NURSING FACILITY	0	0	0		31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	3	0	3		40.00
41.00	04100	LABORATORY	0	0	0		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	4	0	4		43.00
44.00	04400	PHYSICAL THERAPY	6,823	0	6,823		44.00
45.00	04500	OCCUPATIONAL THERAPY	15	0	15		45.00
46.00	04600	SPEECH PATHOLOGY	6	0	6		46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	9	0	9		49.00
51.00	05100	SUPPORT SURFACES	0	0	0		51.00
		OUTPATIENT SERVICE COST CENTERS					
62.00	06200	FQHC					62.00
		OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	0		70.00
71.00	07100	AMBULANCE	0	0	0		71.00
73.00	07300	CMHC	0	0	0		73.00
		SPECIAL PURPOSE COST CENTERS					
89.00		SUBTOTALS (sum of lines 1-84)	125,141	0	125,141		89.00
		NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90.00
91.00	09100	BARBER & BEAUTY SHOP	1	0	1		91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0	0		93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0		94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0		95.00
98.00		Cross Foot Adjustments	0	0	0		98.00
99.00		Negative Cost Centers	0	0	0		99.00
100.00		TOTAL	125,142	0	125,142		100.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDGS & FIXTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
			1.00	3.00	4A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	7,500					1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,855,362				3.00
4.00	00400	ADMINISTRATIVE & GENERAL	125	254,403	-815,566	2,546,338		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	50	52,921	0	168,265	7,325	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	200	18,795	0	32,698	200	6.00
7.00	00700	HOUSEKEEPING	50	69,711	0	102,902	50	7.00
8.00	00800	DIETARY	300	157,507	0	308,672	300	8.00
9.00	00900	NURSING ADMINISTRATION	125	123,114	0	148,806	125	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	50	0	0	71,586	50	10.00
11.00	01100	PHARMACY	0	0	0	11,234	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	50	0	0	834	50	12.00
13.00	01300	SOCIAL SERVICE	0	52,868	0	63,005	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	66,194	0	95,448	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	6,150	998,093	0	1,441,487	6,150	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	3,472	0	40.00
41.00	04100	LABORATORY	0	0	0	114	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	5,402	0	43.00
44.00	04400	PHYSICAL THERAPY	400	39,551	0	53,808	400	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	15,791	0	18,819	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	6,414	0	7,644	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	10,859	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	7,500	1,855,362	-815,566	2,545,055	7,325	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	1,283	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
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	125,142	355,741		815,566	222,159	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	16.685600	0.191737		0.320290	30.328874	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)		0		2,086	972	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)		0.000000		0.000819	0.132696	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS						3.00
4.00	00400	ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600	LAUNDRY & LINEN SERVICE	10,377					6.00
7.00	00700	HOUSEKEEPING	0	7,075				7.00
8.00	00800	DIETARY	0	300	10,377			8.00
9.00	00900	NURSING ADMINISTRATION	0	125	0	10,377		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	50	0	0	10,377	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	50	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	10,377	6,150	10,377	10,377	10,377	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	400	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
		SPECIAL PURPOSE COST CENTERS						
89.00		SUBTOTALS (sum of lines 1-84)	10,377	7,075	10,377	10,377	10,377	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	49,237	137,376	422,461	202,685	97,001	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	4.744820	19.417102	40.711285	19.532138	9.347692	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	3,391	925	5,338	2,241	907	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.326780	0.130742	0.514407	0.215958	0.087405	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT DAYS)		
			11.00	12.00	13.00	15.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS						3.00
4.00	00400	ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600	LAUNDRY & LINEN SERVICE						6.00
7.00	00700	HOUSEKEEPING						7.00
8.00	00800	DIETARY						8.00
9.00	00900	NURSING ADMINISTRATION						9.00
10.00	01000	CENTRAL SERVICES & SUPPLY						10.00
11.00	01100	PHARMACY	10,377					11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	10,377				12.00
13.00	01300	SOCIAL SERVICE	0	0	10,377			13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	10,377		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	10,377	10,377	10,377	10,377		30.00
31.00	03100	NURSING FACILITY	0	0	0	0		31.00
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	0	0	0		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0		45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0		46.00
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
51.00	05100	SUPPORT SURFACES	0	0	0	0		51.00
		OUTPATIENT SERVICE COST CENTERS						
62.00	06200	FQHC						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						
89.00		SUBTOTALS (sum of lines 1-84)	10,377	10,377	10,377	10,377		89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0		90.00
91.00	09100	BARBER & 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
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0		95.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	14,832	3,588	83,185	126,019		102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	1.429315	0.345765	8.016286	12.144069		103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	9	849	52	78		104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.000867	0.081816	0.005011	0.007517		105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C | Date/Time Prepared: 8/23/2024 11:45 pm

		Cost Center Description	Total (from Wkst. B, Pt I, 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	4,584	3,472	1.320276	40.00
41.00	04100	LABORATORY	151	114	1.324561	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	7,132	5,402	1.320252	43.00
44.00	04400	PHYSICAL THERAPY	90,941	39,551	2.299335	44.00
45.00	04500	OCCUPATIONAL THERAPY	24,847	15,791	1.573491	45.00
46.00	04600	SPEECH PATHOLOGY	10,092	6,414	1.573433	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	14,337	10,859	1.320287	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
		OUTPATIENT SERVICE COST CENTERS				
62.00	06200	FQHC				62.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	152,084	81,603		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 8/23/2024 11:45 pm
	Title XVIII (1)	Skilled Nursing Facility	PPS

				Health Care Program Charges		Health Care Program Cost		
			Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
			1.00	2.00	3.00	4.00	5.00	
	PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
	ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	1.320276	0	0	0	0	40.00
41.00	04100	LABORATORY	1.324561	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	1.320252	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	2.299335	3,473	0	7,986	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	1.573491	465	0	732	0	45.00
46.00	04600	SPEECH PATHOLOGY	1.573433	0	0	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	1.320287	4,092	0	5,403	0	49.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS							
62.00	06200	FQHC						62.00
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		8,030	0	14,121	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.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 8/23/2024 11:45 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)	1.320287	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	0	3.00

		Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH						
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	4,584	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	151	0	0.000000	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	7,132	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	90,941	0	0.000000	7,986	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	24,847	0	0.000000	732	0	45.00
46.00	04600	SPEECH PATHOLOGY	10,092	0	0.000000	0	0	46.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	14,337	0	0.000000	5,403	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	152,084	0		14,121	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 8/23/2024 11:45 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS		
	INPATIENT DAYS		
1.00	Inpatient days including private room days	10,377	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	209	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	3,208,126	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	4,027,440	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.796567	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	4,027,440	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	388.11	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)	3,208,126	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	309.16	16.00
17.00	Program routine service cost (Line 3 times line 16)	64,614	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)	64,614	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)	118,281	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	11.40	21.00
22.00	Program capital related cost (Line 3 times line 21)	2,383	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	62,231	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)	62,231	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	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	10,377	1.00
2.00	Program inpatient days (see instructions)	209	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)	0.020141	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.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 8/23/2024 11:45 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
1.00	Inpatient PPS amount (See Instructions)	110,276	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)	110,276	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	11,600	5.00
6.00	Allowable bad debts (From your records)	0	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	0	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)	98,676	11.00
12.00	Interim payments (See instructions)	96,702	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)	0	14.75
14.99	Sequestration amount (see instructions)	1,974	14.99
15.00	Balance due provider/program (see Instructions)	0	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY		
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	0	19.00
20.00	Medicare Part B ancillary charges (See instructions)	0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	0	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0	25.00
26.00	Interim payments (See instructions)	0	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	0	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part II Date/Time Prepared: 8/23/2024 11:45 pm
	Title XIX	Skilled Nursing Facility	Cost

		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 semiprivate accommodations and less than semiprivate 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 semiprivate accommodations and less than semiprivate 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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 | Date/Time Prepared: 8/23/2024 11:45 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		96,702		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		96,702		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		0		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		96,702		0	7.00

		Contractor Name	Contractor Number	
		1.00	2.00	
8.00	Name of Contractor			8.00

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

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

Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 8/23/2024 11:45 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	-669,260	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	1,354,912	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	0	0	0	0	6.00
7.00	Inventory	6,150	0	0	0	7.00
8.00	Prepaid expenses	72,200	0	0	0	8.00
9.00	Other current assets	2,270	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)	766,272	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	315,307	0	0	0	17.00
18.00	Less: Accumulated Amortization	-121,522	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	122,842	0	0	0	21.00
22.00	Less: Accumulated depreciation	-73,845	0	0	0	22.00
23.00	Major movable equipment	424,222	0	0	0	23.00
24.00	Less: Accumulated depreciation	-418,660	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)	248,344	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	0	0	0	0	31.00
32.00	Other assets	600,000	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	600,000	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	1,614,616	0	0	0	34.00
	Liabilities and Fund Balances					
	CURRENT LIABILITIES					
35.00	Accounts payable	261,181	0	0	0	35.00
36.00	Salaries, wages, and fees payable	51,191	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0				40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	-29,114	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	283,258	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	69,777	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	69,777	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	353,035	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,261,581				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	1,261,581	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	1,614,616	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider No.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 8/23/2024 11:45 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		1,245,896		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		15,685				2.00
3.00	Total (sum of line 1 and line 2)		1,261,581		0		3.00
4.00	Additions (credit adjustments)						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	Total additions (sum of line 5 - 9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,261,581		0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		1,261,581		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			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.: 315467 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I-II | Date/Time Prepared: 8/23/2024 11:45 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	4,027,440		4,027,440	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)	4,027,440		4,027,440	5.00
	All Other Care Services				
6.00	ANCILLARY SERVICES	44,064	0	44,064	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	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	4,071,504	0	4,071,504	14.00

	Cost Center Description		1.00	2.00	
	PART II - OPERATING EXPENSES				
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			3,539,551	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)			3,539,551	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315467	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 8/23/2024 11:45 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	4,071,504	1.00
2.00	Less: contractual allowances and discounts on patients accounts	900,140	2.00
3.00	Net patient revenues (Line 1 minus line 2)	3,171,364	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	3,539,551	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-368,187	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	182	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	50,692	24.00
24.50	COVID-19 PHE Funding	332,998	24.50
25.00	Total other income (Sum of lines 6 - 24)	383,872	25.00
26.00	Total (Line 5 plus line 25)	15,685	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)	15,685	31.00