

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: 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/29/2024 6:40 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/29/2024 Time: 6:40 pm	
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Contractor No. _____	7. <input type="checkbox"/> First Cost Report for this Provider CCN
	5. Date Received: _____	8. <input type="checkbox"/> Last Cost Report for this Provider CCN	9. NPR Date: _____
		10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened	11. Contractor Vendor Code <u>4</u>
		12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMPLETE CARE AT BAYSHORE ( 315252 ) for the cost reporting period beginning 03/16/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00 SKILLED NURSING FACILITY	0	84,675	167	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	84,675	167	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 6:40 pm					
1.00		2.00		3.00					
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:									
1.00	Street: 715 NORTH BEERS STREET	PO Box:				1.00			
2.00	City: HOLMDEL	State: NJ	Zip Code: 07733			2.00			
3.00	County: MONMOUTH	CBSA Code: 35154	Urban/Rural: U			3.00			
3.01		CBSA Code:				3.01			
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)				
		1.00	2.00	3.00	V	XVIII	XIX		
					4.00	5.00	6.00		
SNF and SNF-Based Component Identification:									
4.00	SNF	COMPLETE CARE AT BAYSHORE	315252	01/01/1988	N	P	N	4.00	
5.00	Nursing Facility							5.00	
6.00	ICF/IID							6.00	
7.00	SNF-Based HHA							7.00	
8.00	SNF-Based RHC							8.00	
9.00	SNF-Based FQHC							9.00	
10.00	SNF-Based CMHC							10.00	
11.00	SNF-Based OLTC							11.00	
12.00	SNF-Based HOSPICE							12.00	
13.00	SNF-Based CORF							13.00	
				From:	To:				
				1.00	2.00				
14.00	Cost Reporting Period (mm/dd/yyyy)			03/16/2023	12/31/2023		14.00		
15.00	Type of Control (See Instructions)			2LLC			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					544,933	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					544,933	23.00		
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	24.00		
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N	25.00		
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	26.00		
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N	27.00		
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	28.00		
				Part A	Part B	Other			
				1.00	2.00	3.00			
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.									
29.00	Skilled Nursing Facility					N	N	N	29.00
30.00	Nursing Facility								30.00
31.00	ICF/IID								31.00
32.00	SNF-Based HHA					N	N		32.00
33.00	SNF-Based RHC								33.00
34.00	SNF-Based FQHC								34.00
35.00	SNF-Based CMHC						N		35.00
36.00	SNF-Based OLTC								36.00
				Y/N					
				1.00			2.00		
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y			37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N			38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.								39.00
			Premiums	Paid Losses	Self Insurance				
			1.00	2.00	3.00				
41.00	List malpractice premiums and paid losses:			0	0	0		41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 6:40 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. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 6:40 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	Y	03/15/2023	1.00	
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y		9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		N		10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N		11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N		12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	05/02/2024	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. : 315252

Period:  
 From 03/16/2023  
 To 12/31/2023

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/29/2024 6:40 pm

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

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

Provider No. : 315252

Period:  
 From 03/16/2023  
 To 12/31/2023

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/29/2024 6:40 pm

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	05/02/2024	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PREPARER	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

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

Provider No. : 315252

Period:  
 From 03/16/2023  
 To 12/31/2023

Worksheet S-3  
 Part I  
 Date/Time Prepared:  
 5/29/2024 6:40 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	232	67,512	0	7,132	24,520	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	232	67,512	0	7,132	24,520	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	6,489	38,141	0	218	18	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	6,489	38,141	0	218	18	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	298	534	0.00	32.72	1,362.22	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	298	534	0.00	32.72	1,362.22	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX		Other
		16.00	17.00	18.00	19.00		20.00
1.00	SKILLED NURSING FACILITY	71.43	0	263	20	263	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	71.43	0	263	20	263	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	546	125.40	0.00		1.00	
2.00	NURSING FACILITY	0	0.00	0.00		2.00	
3.00	ICF/IID	0	0.00	0.00		3.00	
4.00	HOME HEALTH AGENCY COST					4.00	
5.00	Other Long Term Care	0	0.00	0.00		5.00	
6.00	SNF-Based CMHC					6.00	
7.00	HOSPICE	0	0.00	0.00		7.00	
8.00	Total (Sum of lines 1-7)	546	125.40	0.00		8.00	

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/29/2024 6:40 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - DIRECT SALARIES</b>						
<b>SALARIES</b>						
1.00	Total salaries (See Instructions)	7,215,071	0	7,215,071	207,897.00	34.71 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)	7,215,071	0	7,215,071	207,897.00	34.71 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST					
9.00	CMHC					
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	7,215,071	0	7,215,071	207,897.00	34.71 13.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	3,081,089	0	3,081,089	58,149.00	52.99 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	1,448,507	0	1,448,507		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	1,448,507	0	1,448,507		



SNF WAGE INDEX INFORMATION

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/29/2024 6:40 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - OVERHEAD COST - DIRECT SALARIES</b>						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	640,140	0	640,140	15,535.00	2.00
3.00	Plant Operation, Maintenance & Repairs	107,819	0	107,819	3,149.00	3.00
4.00	Laundry & Linen Service	0	0	0	0.00	4.00
5.00	Housekeeping	503,487	0	503,487	24,518.00	5.00
6.00	Dietary	666,610	0	666,610	30,889.00	6.00
7.00	Nursing Administration	538,031	0	538,031	9,156.00	7.00
8.00	Central Services and Supply	28,224	0	28,224	1,012.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	59,021	0	59,021	1,407.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	180,748	0	180,748	8,953.00	13.00
14.00	Total (sum lines 1 thru 13)	2,724,080	0	2,724,080	94,619.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2024 6:40 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		511,289	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		18,059	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		11,831	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		182,815	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		528,853	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		195,660	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		1,448,507	24.00
				Amount Reported
				1.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/29/2024 6:40 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	744,924	153,678	898,602	13,729.00	65.45	1.00
2.00	Licensed Practical Nurses (LPNs)	1,399,532	288,723	1,688,255	30,933.00	54.58	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,580,989	326,158	1,907,147	61,556.00	30.98	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,725,445	768,559	4,494,004	106,218.00	42.31	4.00
5.00	Physical Therapists	77,730	16,036	93,766	1,478.00	63.44	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	47,305	9,759	57,064	1,090.00	52.35	8.00
9.00	Occupational Therapy Assistants	9,429	1,945	11,374	239.00	47.59	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	13,150	2,713	15,863	280.00	56.65	11.00
12.00	Respiratory Therapists	617,931	127,479	745,410	3,974.00	187.57	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
<b>Contract Labor</b>							
<b>Nursing Occupations</b>							
14.00	Registered Nurses (RNs)	178,352		178,352	2,325.00	76.71	14.00
15.00	Licensed Practical Nurses (LPNs)	1,029,412		1,029,412	15,664.00	65.72	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,133,934		1,133,934	25,753.00	44.03	16.00
17.00	Total Nursing (sum of lines 14 through 16)	2,341,698		2,341,698	43,742.00	53.53	17.00
18.00	Physical Therapists	263,204		263,204	5,474.00	48.08	18.00
19.00	Physical Therapy Assistants	64,808		64,808	1,483.00	43.70	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	262,157		262,157	4,667.00	56.17	21.00
22.00	Occupational Therapy Assistants	62,543		62,543	1,225.00	51.06	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	86,680		86,680	1,558.00	55.64	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. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet S-7  
Date/Time Prepared:  
5/29/2024 6:40 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. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet S-7

Date/Time Prepared:  
5/29/2024 6:40 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet A  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		2,953,946	2,953,946	0	2,953,946	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,488,207	1,488,207	0	1,488,207	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	640,140	2,044,224	2,684,364	0	2,684,364	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	107,819	437,844	545,663	0	545,663	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	8,989	8,989	0	8,989	6.00
7.00	00700	HOUSEKEEPING	503,487	50,053	553,540	0	553,540	7.00
8.00	00800	DIETARY	666,610	759,123	1,425,733	0	1,425,733	8.00
9.00	00900	NURSING ADMINISTRATION	538,031	0	538,031	0	538,031	9.00
10.00	01000	CENTRAL SERVICE & SUPPLY	28,224	351,317	379,541	0	379,541	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	59,021	8,775	67,796	0	67,796	13.00
15.00	01500	PATIENT ACTIVITIES	180,748	53,370	234,118	0	234,118	15.00
15.10	01510	REHAB TECH	0	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	3,725,445	2,613,732	6,339,177	0	6,339,177	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	27,185	27,185	0	27,185	40.00
41.00	04100	LABORATORY	0	49,921	49,921	0	49,921	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	617,931	5,735	623,666	0	623,666	43.00
44.00	04400	PHYSICAL THERAPY	77,730	332,365	410,095	0	410,095	44.00
45.00	04500	OCCUPATIONAL THERAPY	56,735	325,295	382,030	0	382,030	45.00
46.00	04600	SPEECH PATHOLOGY	13,150	86,833	99,983	0	99,983	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	372,736	372,736	0	372,736	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	11,913	11,913	0	11,913	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
81.00	08100	INTEREST EXPENSE	0	0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	7,215,071	11,981,563	19,196,634	0	19,196,634	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	ASSISTED LIVING	0	0	0	0	0	95.00
100.00		TOTAL	7,215,071	11,981,563	19,196,634	0	19,196,634	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet A  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	544,967	3,498,913	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,488,207	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-442,723	2,241,641	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	545,663	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	8,989	6.00
7.00	00700	HOUSEKEEPING	0	553,540	7.00
8.00	00800	DIETARY	-80	1,425,653	8.00
9.00	00900	NURSING ADMINISTRATION	0	538,031	9.00
10.00	01000	CENTRAL SERVICE & SUPPLY	0	379,541	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	67,796	13.00
15.00	01500	PATIENT ACTIVITIES	0	234,118	15.00
15.10	01510	REHAB TECH	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	0	6,339,177	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	0	27,185	40.00
41.00	04100	LABORATORY	0	49,921	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	623,666	43.00
44.00	04400	PHYSICAL THERAPY	0	410,095	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	382,030	45.00
46.00	04600	SPEECH PATHOLOGY	0	99,983	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	372,736	49.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
71.00	07100	AMBULANCE	0	11,913	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	102,164	19,298,798	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	ASSISTED LIVING	0	0	95.00
100.00		TOTAL	102,164	19,298,798	100.00

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet A-6

Date/Time Prepared:  
5/29/2024 6:40 pm

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

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



Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/29/2024 6:40 pm
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		Decreases			
		Cost Center	Line #	Salary	Non Salary
		6.00	7.00	8.00	9.00
100.00	TOTALS			0	0
					100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet A-7

Date/Time Prepared:  
5/29/2024 6:40 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	0	39,893	0	39,893	4.00
5.00	Fixed Equipment	0	20,275	0	20,275	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	0	60,168	0	60,168	7.00
8.00	Reconciling Items	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	0	60,168	0	60,168	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	39,893	0			4.00
5.00	Fixed Equipment	20,275	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	Subtotal (sum of lines 1-6)	60,168	0			7.00
8.00	Reconciling Items	0	0			8.00
9.00	Total (line 7 minus line 8)	60,168	0			9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet A-8

Date/Time Prepared:  
5/29/2024 6:40 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
1.00 Investment income on restricted funds (chapter 2)	B	-11,730	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	452,097			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Revenue - Employee meals		0			0.00 14.00
15.00 Cost of meals - Guests		0			0.00 15.00
16.00 Sale of medical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts	B	-1,249	ADMINISTRATIVE & GENERAL		4.00 18.00
19.00 Vending machines	B	-80	DIETARY		8.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00 22.00
23.00 Depreciation--buildings and fixtures			CAP REL COSTS - BLDGS & FIXTURES		1.00 23.00
24.00 Depreciation--movable equipment			*** Cost Center Deleted ***		2.00 24.00
25.00 OTHER REVENUE - CARRYOVER PTO	B	-99,368	ADMINISTRATIVE & GENERAL		4.00 25.00
25.01 OTHER REVENUE - GIFT SHOP	B	-833	ADMINISTRATIVE & GENERAL		4.00 25.01
25.02 RESIDENT MISSING ITEMS	A	-69	ADMINISTRATIVE & GENERAL		4.00 25.02
25.03 MARKETING	A	-47,643	ADMINISTRATIVE & GENERAL		4.00 25.03
25.04 BAD DEBTS	A	-188,961	ADMINISTRATIVE & GENERAL		4.00 25.04
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		102,164			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. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet A-8-1  
Parts I-11  
Date/Time Prepared:  
5/29/2024 6:40 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00
2.00	4.00	ADMINISTRATIVE & GENERAL	REALTY A&G COSTS	2.00
3.00	4.00	ADMINISTRATIVE & GENERAL	COMPLETE CARE MANAGEMENT	3.00
4.00	0.00			4.00
5.00	0.00			5.00
6.00	0.00			6.00
7.00	0.00			7.00
8.00	0.00			8.00
9.00	0.00			9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00
	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
	4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	3,020,594	2,463,897	556,697	1.00
2.00	25,858	0	25,858	2.00
3.00	676,695	807,153	-130,458	3.00
4.00	0	0	0	4.00
5.00	0	0	0	5.00
6.00	0	0	0	6.00
7.00	0	0	0	7.00
8.00	0	0	0	8.00
9.00	0	0	0	9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00
	3,723,147	3,271,050	452,097	

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/29/2024 6:40 pm
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Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	B	PC HMH OPCO HOLDINGS LLC	100.00	1.00
2.00	B	PEACE CAPITAL LLC	100.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
10.05			0.00	10.05
10.06			0.00	10.06
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00	PC HMH PROPCO HOLDING LLC	100.00	REALTY	1.00
2.00	COMPLETE CARE MANAGEMENT	100.00	MANAGEMENT OF FACILITY	2.00
3.00		0.00		3.00
4.00		0.00		4.00
5.00		0.00		5.00
6.00		0.00		6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
10.05		0.00		10.05
10.06		0.00		10.06
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADM NI STRATI VE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	3,498,913	3,498,913			1.00
3.00 00300	EMPLOYEE BENEFITS	1,488,207	0	1,488,207		3.00
4.00 00400	ADM NI STRATI VE & GENERAL	2,241,641	189,797	132,038	2,563,476	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	545,663	58,518	22,239	626,420	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	8,989	80,735	0	89,724	6.00
7.00 00700	HOUSEKEEPING	553,540	17,496	103,851	674,887	7.00
8.00 00800	DI ETARY	1,425,653	247,086	137,498	1,810,237	8.00
9.00 00900	NURSI NG ADM NI STRATI ON	538,031	133,144	110,976	782,151	9.00
10.00 01000	CENTRAL SERVICE & SUPPLY	379,541	0	5,822	385,363	10.00
12.00 01200	MEDI CAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCI AL SERVICE	67,796	11,466	12,174	91,436	13.00
15.00 01500	PATI ENT ACTI VI TI ES	234,118	165,359	37,282	436,759	15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKI LLED NURSI NG FACI LI TY	6,339,177	2,548,657	768,423	9,656,257	30.00
31.00 03100	NURSI NG FACI LI TY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADI OLOGY	27,185	0	0	27,185	40.00
41.00 04100	LABORATORY	49,921	0	0	49,921	41.00
42.00 04200	INTRA VENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	623,666	0	127,457	751,123	43.00
44.00 04400	PHYSI CAL THERAPY	410,095	19,995	16,033	446,123	44.00
45.00 04500	OCCUPATI ONAL THERAPY	382,030	19,995	11,702	413,727	45.00
46.00 04600	SPEECH PATHOLOGY	99,983	0	2,712	102,695	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATI ENTS	372,736	0	0	372,736	49.00
51.00 05100	SUPPOR T SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	11,913	0	0	11,913	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTI LI ZATI ON REVI EW - SNF					82.00
83.00 08300	HOSPI CE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	19,298,798	3,492,248	1,488,207	19,292,133	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	6,665	0	6,665	91.00
92.00 09200	PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATI ENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	ASSI STED LI VI NG	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	99.00
100.00	TOTAL	19,298,798	3,498,913	1,488,207	19,298,798	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2024 6:40 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	722,374				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	17,942	121,410			6.00
7.00	00700	HOUSEKEEPING	3,888	0	782,153		7.00
8.00	00800	DIETARY	54,909	0	61,306	2,203,740	8.00
9.00	00900	NURSING ADMINISTRATION	29,588	0	33,035	0	9.00
10.00	01000	CENTRAL SERVICE & SUPPLY	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	2,548	0	2,845	0	13.00
15.00	01500	PATIENT ACTIVITIES	36,747	0	41,028	0	15.00
15.10	01510	REHAB TECH	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	566,383	121,410	632,363	2,203,740	964,582
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	4,444	0	4,961	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	4,444	0	4,961	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	AMBULANCE	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	720,893	121,410	780,499	2,203,740	964,582
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	1,481	0	1,654	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	ASSISTED LIVING	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	99.00
100.00		TOTAL	722,374	121,410	782,153	2,203,740	964,582

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE		
				PATIENT ACTIVITIES	REHAB TECH	
				10.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7.00 00700 HOUSEKEEPING						7.00
8.00 00800 DIETARY						8.00
9.00 00900 NURSING ADMINISTRATION						9.00
10.00 01000 CENTRAL SERVICE & SUPPLY	444,392					10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
13.00 01300 SOCIAL SERVICE	0	0	110,835			13.00
15.00 01500 PATIENT ACTIVITIES	0	0	0	581,436		15.00
15.10 01510 REHAB TECH	0	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 SKILLED NURSING FACILITY	215,623	0	110,835	581,436	0	30.00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200 ICF/IID	0	0	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000 RADIOLOGY	0	0	0	0	0	40.00
41.00 04100 LABORATORY	0	0	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400 PHYSICAL THERAPY	0	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
47.00 04700 ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	228,769	0	0	0	0	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100 AMBULANCE	0	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
81.00 08100 INTEREST EXPENSE						81.00
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83.00 08300 HOSPICE	0	0	0	0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	444,392	0	110,835	581,436	0	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500 ASSISTED LIVING	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	444,392	0	110,835	581,436	0	100.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description		Subtotal	Post Stepdown Adjustments	Total	
		16.00	17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES			1.00
3.00	00300	EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5.00
6.00	00600	LAUNDRY & LINEN SERVICE			6.00
7.00	00700	HOUSEKEEPING			7.00
8.00	00800	DIETARY			8.00
9.00	00900	NURSING ADMINISTRATION			9.00
10.00	01000	CENTRAL SERVICE & SUPPLY			10.00
12.00	01200	MEDICAL RECORDS & LIBRARY			12.00
13.00	01300	SOCIAL SERVICE			13.00
15.00	01500	PATIENT ACTIVITIES			15.00
15.10	01510	REHAB TECH			15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	16,531,747	0	16,531,747
31.00	03100	NURSING FACILITY	0	0	0
32.00	03200	ICF/IID	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	31,349	0	31,349
41.00	04100	LABORATORY	57,568	0	57,568
42.00	04200	INTRAVENOUS THERAPY	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	866,179	0	866,179
44.00	04400	PHYSICAL THERAPY	523,864	0	523,864
45.00	04500	OCCUPATIONAL THERAPY	486,506	0	486,506
46.00	04600	SPEECH PATHOLOGY	118,426	0	118,426
47.00	04700	ELECTROCARDIOLOGY	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	658,600	0	658,600
51.00	05100	SUPPORT SURFACES	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
71.00	07100	AMBULANCE	13,738	0	13,738
<b>SPECIAL PURPOSE COST CENTERS</b>					
81.00	08100	INTEREST EXPENSE			81.00
82.00	08200	UTILIZATION REVIEW - SNF			82.00
83.00	08300	HOSPICE	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	19,287,977	0	19,287,977
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	10,821	0	10,821
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0
95.00	09500	ASSISTED LIVING	0	0	0
98.00		Cross Foot Adjustments	0	0	0
99.00		Negative Cost Centers	0	0	0
100.00		TOTAL	19,298,798	0	19,298,798

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	2A	3.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	189,797	189,797	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	58,518	58,518	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	80,735	80,735	0	6.00
7.00 00700	HOUSEKEEPING	0	17,496	17,496	0	7.00
8.00 00800	DIETARY	0	247,086	247,086	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	133,144	133,144	0	9.00
10.00 01000	CENTRAL SERVICE & SUPPLY	0	0	0	0	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	11,466	11,466	0	13.00
15.00 01500	PATIENT ACTIVITIES	0	165,359	165,359	0	15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	0	2,548,657	2,548,657	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	19,995	19,995	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	19,995	19,995	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	3,492,248	3,492,248	0	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	6,665	6,665	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	ASSISTED LIVING	0	0	0	0	95.00
98.00	Cross Foot Adjustments			0		98.00
99.00	Negative Cost Centers			0		99.00
100.00	TOTAL	0	3,498,913	3,498,913	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2024 6:40 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	65,622				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	1,630	83,383			6.00
7.00	00700	HOUSEKEEPING	353	0	25,503		7.00
8.00	00800	DIETARY	4,988	0	1,999	274,603	8.00
9.00	00900	NURSING ADMINISTRATION	2,688	0	1,077	0	145,779
10.00	01000	CENTRAL SERVICE & SUPPLY	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	231	0	93	0	13.00
15.00	01500	PATIENT ACTIVITIES	3,338	0	1,338	0	15.00
15.10	01510	REHAB TECH	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	51,451	83,383	20,618	274,603	145,779
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	404	0	162	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	404	0	162	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	AMBULANCE	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	65,487	83,383	25,449	274,603	145,779
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	135	0	54	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	ASSISTED LIVING	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	99.00
100.00		TOTAL	65,622	83,383	25,503	274,603	145,779

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE		
				PATIENT ACTIVITIES	REHAB TECH	
				10.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7.00 00700 HOUSEKEEPING						7.00
8.00 00800 DIETARY						8.00
9.00 00900 NURSING ADMINISTRATION						9.00
10.00 01000 CENTRAL SERVICE & SUPPLY	4,370					10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
13.00 01300 SOCIAL SERVICE	0	0	12,827			13.00
15.00 01500 PATIENT ACTIVITIES	0	0	0	174,988		15.00
15.10 01510 REHAB TECH	0	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 SKILLED NURSING FACILITY	2,120	0	12,827	174,988	0	30.00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200 ICF/IID	0	0	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000 RADIOLOGY	0	0	0	0	0	40.00
41.00 04100 LABORATORY	0	0	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400 PHYSICAL THERAPY	0	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
47.00 04700 ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	2,250	0	0	0	0	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100 AMBULANCE	0	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
81.00 08100 INTEREST EXPENSE						81.00
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83.00 08300 HOSPICE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	4,370	0	12,827	174,988	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500 ASSISTED LIVING	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	99.00
100.00	TOTAL	4,370	0	12,827	174,988	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description		Subtotal	Post Step-Down Adjustments	Total	
		16.00	17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
3.00	00300				3.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
12.00	01200				12.00
13.00	01300				13.00
15.00	01500				15.00
15.10	01510				15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	3,423,941	0	3,423,941	30.00
31.00	03100	0	0	0	31.00
32.00	03200	0	0	0	32.00
33.00	03300	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	308	0	308	40.00
41.00	04100	566	0	566	41.00
42.00	04200	0	0	0	42.00
43.00	04300	8,518	0	8,518	43.00
44.00	04400	25,620	0	25,620	44.00
45.00	04500	25,253	0	25,253	45.00
46.00	04600	1,165	0	1,165	46.00
47.00	04700	0	0	0	47.00
48.00	04800	0	0	0	48.00
49.00	04900	6,477	0	6,477	49.00
51.00	05100	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
71.00	07100	135	0	135	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
81.00	08100				81.00
82.00	08200				82.00
83.00	08300	0	0	0	83.00
89.00		3,491,983	0	3,491,983	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	0	0	0	90.00
91.00	09100	6,930	0	6,930	91.00
92.00	09200	0	0	0	92.00
93.00	09300	0	0	0	93.00
94.00	09400	0	0	0	94.00
95.00	09500	0	0	0	95.00
98.00		0	0	0	98.00
99.00		0	0	0	99.00
100.00		3,498,913	0	3,498,913	100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B-1

Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	BLDGS & FIXTURES (SQUARE FEET)					
	1.00	3.00	4A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	88,193				1.00
3.00 00300	EMPLOYEE BENEFITS	0	7,215,071			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	4,784	640,140	-2,563,476	16,735,322	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,475	107,819	0	626,420	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	2,035	0	0	89,724	6.00
7.00 00700	HOUSEKEEPING	441	503,487	0	674,887	7.00
8.00 00800	DIETARY	6,228	666,610	0	1,810,237	8.00
9.00 00900	NURSING ADMINISTRATION	3,356	538,031	0	782,151	9.00
10.00 01000	CENTRAL SERVICE & SUPPLY	0	28,224	0	385,363	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	289	59,021	0	91,436	13.00
15.00 01500	PATIENT ACTIVITIES	4,168	180,748	0	436,759	15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	64,241	3,725,445	0	9,656,257	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	27,185	40.00
41.00 04100	LABORATORY	0	0	0	49,921	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	617,931	0	751,123	43.00
44.00 04400	PHYSICAL THERAPY	504	77,730	0	446,123	44.00
45.00 04500	OCCUPATIONAL THERAPY	504	56,735	0	413,727	45.00
46.00 04600	SPEECH PATHOLOGY	0	13,150	0	102,695	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	372,736	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	11,913	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	88,025	7,215,071	-2,563,476	16,728,657	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	168	0	0	6,665	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	ASSISTED LIVING	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)	3,498,913	1,488,207		2,563,476	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	39.673364	0.206264		0.153178	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		189,797	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.011341	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B-1

Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS HRS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)		
		6.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	38,141				6.00	
7.00	00700	HOUSEKEEPING	0	79,458			7.00	
8.00	00800	DIETARY	0	6,228	114,423		8.00	
9.00	00900	NURSING ADMINISTRATION	0	3,356	0	106,218	9.00	
10.00	01000	CENTRAL SERVICE & SUPPLY	0	0	0	724,053	10.00	
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00	
13.00	01300	SOCIAL SERVICE	0	289	0	0	13.00	
15.00	01500	PATIENT ACTIVITIES	0	4,168	0	0	15.00	
15.10	01510	REHAB TECH	0	0	0	0	15.10	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	38,141	64,241	114,423	106,218	351,317	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	504	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	504	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	372,736	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	38,141	79,290	114,423	106,218	724,053	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	168	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	ASSISTED LIVING	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)	121,410	782,153	2,203,740	964,582	444,392	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	3.183189	9.843603	19.259589	9.081154	0.613756	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	83,383	25,503	274,603	145,779	4,370	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	2.186178	0.320962	2.399893	1.372451	0.006035	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet B-1

Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	OTHER GENERAL SERVICE			
			PATIENT ACTIVITIES (PATIENT CENSUS)	REHAB TECH (DIRECT COST)		
			12.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICE & SUPPLY					10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	38,141				12.00
13.00 01300	SOCIAL SERVICE	0	38,141			13.00
15.00 01500	PATIENT ACTIVITIES	0	0	38,141		15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	38,141	38,141	38,141	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	0	71.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	38,141	38,141	38,141	0	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	ASSISTED LIVING	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)	0	110,835	581,436	0	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	2.905928	15.244383	0.000000	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	0	12,827	174,988	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.336305	4.587924	0.000000	105.00



RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/29/2024 6:40 pm	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	31,349	0	0.000000 40.00
41.00	04100	LABORATORY	57,568	10,171	5.660014 41.00
42.00	04200	INTRAVENOUS THERAPY	0	35	0.000000 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	866,179	0	0.000000 43.00
44.00	04400	PHYSICAL THERAPY	523,864	655,799	0.798818 44.00
45.00	04500	OCCUPATIONAL THERAPY	486,506	656,892	0.740618 45.00
46.00	04600	SPEECH PATHOLOGY	118,426	269,577	0.439303 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000 47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	658,600	372,736	1.766934 49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000 51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	07100	AMBULANCE	13,738	0	0.000000 71.00
100.00		Total	2,756,230	1,965,210	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/29/2024 6:40 pm
		Title XVIII (1)	Skilled Nursing Facility	PPS

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
			1.00	2.00	3.00	4.00		5.00
<b>PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST</b>								
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0.000000	0	0	0	0	40.00
41.00	04100	LABORATORY	5.660014	10,145	0	57,421	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	35	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.798818	312,755	0	249,834	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.740618	319,680	0	236,761	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.439303	131,815	0	57,907	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	1.766934	207,773	0	367,121	0	49.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		982,203	0	969,044	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. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/29/2024 6:40 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.766934	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	310	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	548	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	31,349	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	57,568	0	0.000000	57,421	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	866,179	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	523,864	0	0.000000	249,834	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	486,506	0	0.000000	236,761	0	45.00
46.00	04600	SPEECH PATHOLOGY	118,426	0	0.000000	57,907	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	658,600	0	0.000000	367,121	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	2,742,492	0		969,044	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/29/2024 6:40 pm
	Title XVIII	Skilled Nursing Facility	PPS

	1.00	
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PART I CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1.00	Inpatient days including private room days	38,141	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	7,132	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	16,531,747	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6.00	General inpatient routine service charges	15,568,566	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	1.061867	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	16,531,747	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	433.44	16.00
17.00	Program routine service cost (Line 3 times line 16)	3,091,294	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)	3,091,294	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)	3,423,941	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	89.77	21.00
22.00	Program capital related cost (Line 3 times line 21)	640,240	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	2,451,054	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)	2,451,054	25.00
26.00	Enter the per diem limitation (1)		26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00

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

	1.00	
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PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days	38,141	1.00
2.00	Program inpatient days (see instructions)	7,132	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)	0.186990	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. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/29/2024 6:40 pm
		Title XVIII	Skilled Nursing Facility	PPS

			1.00	
<b>PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT</b>				
1.00	Inpatient PPS amount (See Instructions)		5,855,099	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)		5,855,099	3.00
4.00	Primary payor amounts		42,010	4.00
5.00	Coinsurance		824,345	5.00
6.00	Allowable bad debts (From your records)		75,840	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		61,800	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		49,296	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)		5,038,040	11.00
12.00	Interim payments (See instructions)		4,852,604	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)		986	14.75
14.99	Sequestration amount (see instructions)		99,775	14.99
15.00	Balance due provider/program (see Instructions)		84,675	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
<b>PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY</b>				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		548	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		548	19.00
20.00	Medicare Part B ancillary charges (See instructions)		310	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		310	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		310	25.00
26.00	Interim payments (See instructions)		137	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)		6	28.99
29.00	Balance due provider/program (see instructions)		167	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315252	Period: From 03/16/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/29/2024 6:40 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				137	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		4,888,969		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	07/13/2023	36,365		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)		-36,365		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)		4,852,604		137	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		84,675		167	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,937,279		304	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. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet G

Date/Time Prepared:  
5/29/2024 6:40 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>Assets</b>						
<b>CURRENT ASSETS</b>						
1.00	Cash on hand and in banks	46,744	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,889,900	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	-179,539	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	123,412	0	0	0	8.00
9.00	Other current assets	38,614	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	<b>TOTAL CURRENT ASSETS (Sum of lines 1 - 10)</b>	<b>4,919,131</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	39,893	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,275	0	0	0	23.00
24.00	Less: Accumulated depreciation	-2,784	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	<b>TOTAL FIXED ASSETS (Sum of lines 12 - 27)</b>	<b>57,384</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28.00</b>
<b>OTHER ASSETS</b>						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	4,459,460	0	0	0	31.00
32.00	Other assets	37,476	0	0	0	32.00
33.00	<b>TOTAL OTHER ASSETS (Sum of lines 29 - 32)</b>	<b>4,496,936</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33.00</b>
34.00	<b>TOTAL ASSETS (Sum of lines 11, 28, and 33)</b>	<b>9,473,451</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34.00</b>
<b>Liabilities and Fund Balances</b>						
<b>CURRENT LIABILITIES</b>						
35.00	Accounts payable	2,817,986	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,486,779	0	0	0	36.00
37.00	Payroll taxes payable	683	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	101,489	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	<b>TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)</b>	<b>4,406,937</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43.00</b>
<b>LONG TERM LIABILITIES</b>						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	1,198,398	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	525,761	0	0	0	47.00
48.00	Other long term liabilities	6,417,359	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	<b>TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)</b>	<b>8,141,518</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>TOTAL LIABILITIES (Sum of lines 43 and 50)</b>	<b>12,548,455</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-3,075,004	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	<b>TOTAL FUND BALANCES (Sum of lines 52 thru 58)</b>	<b>-3,075,004</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>59.00</b>
60.00	<b>TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)</b>	<b>9,473,451</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet G-1

Date/Time Prepared:  
5/29/2024 6:40 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		-21,420		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-3,053,584			2.00
3.00	Total (sum of line 1 and line 2)		-3,075,004		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-3,075,004		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-3,075,004		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. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet G-2  
Parts I-III  
Date/Time Prepared:  
5/29/2024 6:40 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	15,568,566		15,568,566	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)	15,568,566		15,568,566	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,965,210	0	1,965,210	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)	17,533,776	0	17,533,776	14.00
Cost Center Description			1.00	2.00	
<b>PART II - OPERATING EXPENSES</b>					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			19,196,634	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)			19,196,634	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315252

Period:  
From 03/16/2023  
To 12/31/2023

Worksheet G-3

Date/Time Prepared:  
5/29/2024 6:40 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17,533,776	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,503,986	2.00
3.00	Net patient revenues (Line 1 minus line 2)	16,029,790	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	19,196,634	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-3,166,844	5.00
<b>Other income:</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	11,730	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	1,249	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	80	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	NON PATIENT REVENUE	833	24.00
24.01	MISCELLANEOUS	99,368	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	113,260	25.00
26.00	Total (Line 5 plus line 25)	-3,053,584	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)	-3,053,584	31.00