

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: 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/26/2024 12:23 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____ 6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VOORHEES PEDIATRIC FACILITY (315289) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title XVIII			Title XIX	
	Title V	Part A	Part B		
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	0	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	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
7.10 SNF - BASED CORF I	0		0	0	7.10
100.00 TOTAL	0	0	0	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. 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. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/26/2024 12:23 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 1304 LAUREL OAK ROAD	PO Box:				1.00		
2.00	City: VOORHEES	State: NJ	Zip Code: 08043			2.00		
3.00	County: CAMDEN	CBSA Code: 15804	Urban/Rural: U			3.00		
3.01		CBSA Code: 0				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
					4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	VOORHEES PEDIATRIC FACILITY	315289	01/01/2010	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00
				From:	To:			
				1.00	2.00			
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2023	12/31/2023		14.00	
15.00	Type of Control (See Instructions)				4		15.00	
				Y/N				
				1.00				
Type of Freestanding Skilled Nursing Facility								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y		18.00
Miscellaneous Cost Reporting Information								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.01
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					91,286		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					91,286		23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility					N		29.00
30.00	Nursing Facility					N		30.00
31.00	ICF/IID					N		31.00
32.00	SNF-Based HHA					N		32.00
33.00	SNF-Based RHC					N		33.00
34.00	SNF-Based FQHC					N		34.00
35.00	SNF-Based CMHC					N		35.00
36.00	SNF-Based OLTC					N		36.00
				Y/N				
				1.00			2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					N		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. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/26/2024 12:23 pm
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		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	Y	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.	315999	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: NUVISION	Contractor's Name: NOVITAS	Contractor's Number: 15101
46.00	Street: 5310 NW 33RD AVE	PO Box: SUITE 211	
47.00	City: FT LAUDERDALE	State: 12	Zip Code: 33309

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/26/2024 12:23 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)		N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.		N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.		N		8.00
			Y/N		
			1.00		
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
			Part A		Part B
			Description	Date	Y/N
			0	1.00	2.00
			Y/N	Date	Y/N
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		N		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		N		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		N		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		N		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		N		18.00

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

Provider No. : 315289

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/26/2024 12:23 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VARIOUS	VARIOUS	19.00
20.00	Enter the employer/company name of the cost report preparer.	HUBCO HEALTH CARE GROUP		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6099155561	KVK@HUBCO.NET	21.00

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

Provider No. : 315289

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/26/2024 12:23 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STAFF	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. : 315289

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/26/2024 12:23 pm

Component		Number of Beds		Bed Days Available		Inpatient Days/Visits				
						Title V		Title XVIII		Title XIX
						3.00	4.00	5.00	6.00	7.00
1.00	SKILLED NURSING FACILITY	119	43,435	0	0	29,090	1.00	1.00		
2.00	NURSING FACILITY	0	0	0	0	0	2.00	2.00		
3.00	ICF/IID	0	0	0	0	0	3.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00	4.00		
5.00	Other Long Term Care	0	0	0	0	0	5.00	5.00		
6.00	SNF-Based CMHC	0	0	0	0	0	6.00	6.00		
6.10	SNF-Based CORF	0	0	0	0	0	6.10	6.10		
7.00	HOSPICE	0	0	0	0	0	7.00	7.00		
8.00	Total (Sum of lines 1-7)	119	43,435	0	0	29,090	8.00	8.00		
Component		Inpatient Days/Visits		Discharges						
		Other		Title V		Title XVIII	Title XIX			
		6.00	7.00	8.00	9.00	10.00				
1.00	SKILLED NURSING FACILITY	9,394	38,484	0	0	81	1.00	1.00		
2.00	NURSING FACILITY	0	0	0	0	0	2.00	2.00		
3.00	ICF/IID	0	0	0	0	0	3.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00	4.00		
5.00	Other Long Term Care	0	0	0	0	0	5.00	5.00		
6.00	SNF-Based CMHC	0	0	0	0	0	6.00	6.00		
6.10	SNF-Based CORF	0	0	0	0	0	6.10	6.10		
7.00	HOSPICE	0	0	0	0	0	7.00	7.00		
8.00	Total (Sum of lines 1-7)	9,394	38,484	0	0	81	8.00	8.00		
Component		Discharges		Average Length of Stay						
		Other		Title V		Title XVIII	Title XIX			
		11.00	12.00	13.00	14.00	15.00				
1.00	SKILLED NURSING FACILITY	33	114	0.00	0.00	359.14	1.00	1.00		
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00	2.00		
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00	4.00		
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00	5.00		
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00	6.00		
6.10	SNF-Based CORF	0	0	0.00	0.00	0.00	6.10	6.10		
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00	7.00		
8.00	Total (Sum of lines 1-7)	33	114	0.00	0.00	359.14	8.00	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	337.58	0	0	76	70	1.00	1.00		
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00	2.00		
3.00	ICF/IID	0.00	0	0	0	0	3.00	3.00		
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00	4.00		
5.00	Other Long Term Care	0.00	0	0	0	0	5.00	5.00		
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00	6.00		
6.10	SNF-Based CORF	0.00	0	0	0	0	6.10	6.10		
7.00	HOSPICE	0.00	0	0	0	0	7.00	7.00		
8.00	Total (Sum of lines 1-7)	337.58	0	0	76	70	8.00	8.00		
Component		Admissions		Full Time Equivalent						
		Total		Employees on Payroll		Nonpaid Workers				
		21.00	22.00	23.00						
1.00	SKILLED NURSING FACILITY	146	289.73	0.00	0.00	0.00	1.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	0.00	0.00	2.00	2.00		
3.00	ICF/IID	0	0.00	0.00	0.00	0.00	3.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	0.00	0.00	4.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	0.00	0.00	5.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	0.00	0.00	6.00	6.00		
6.10	SNF-Based CORF	0	0.00	0.00	0.00	0.00	6.10	6.10		
7.00	HOSPICE	0	0.00	0.00	0.00	0.00	7.00	7.00		
8.00	Total (Sum of lines 1-7)	146	289.73	0.00	0.00	0.00	8.00	8.00		

Provider No. : 315289

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

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2024 12:23 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	24,663,467	0	24,663,467	602,637.00	40.93 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)	24,663,467	0	24,663,467	602,637.00	40.93 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
9.10	CORF					
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	1,021,758	0	1,021,758	31,685.00	32.25 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	1,021,758	0	1,021,758	31,685.00	32.25 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	23,641,709	0	23,641,709	570,952.00	41.41 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	0	0	0	0.00	0.00 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	6,370,487	0	6,370,487		
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)	6,370,487	0	6,370,487		

Provider No. : 315289

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

Worksheet S-3
Part III
Date/Time Prepared:
5/26/2024 12:23 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	1,656,238	0	1,656,238	45,165.00	2.00
3.00	Plant Operation, Maintenance & Repairs	351,449	0	351,449	14,373.00	3.00
4.00	Laundry & Linen Service	0	0	0.00	0.00	4.00
5.00	Housekeeping	0	0	0.00	0.00	5.00
6.00	Dietary	77,185	0	77,185	2,080.00	6.00
7.00	Nursing Administration	688,656	0	688,656	21,683.00	7.00
8.00	Central Services and Supply	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0.00	0.00	10.00
11.00	Social Service	179,759	0	179,759	3,967.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	907,682	0	907,682	35,462.00	13.00
14.00	Total (sum lines 1 thru 13)	3,860,969	0	3,860,969	122,730.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2024 12:23 pm
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			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		316,655	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,279,221	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		513,834	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,883,415	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		271,983	20.00
OTHER				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		6,265,108	24.00
			Amount Reported	
			1.00	
Part B - Other than Core Related Cost				
25.00	OTHER		105,379	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315289

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

Worksheet S-3
Part V
Date/Time Prepared:
5/26/2024 12:23 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	4,753,096	0	4,753,096	88,681.00	53.60	1.00
2.00	Licensed Practical Nurses (LPNs)	5,798,092	0	5,798,092	127,407.00	45.51	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,114,038	0	1,114,038	40,265.00	27.67	3.00
4.00	Total Nursing (sum of lines 1 through 3)	11,665,226	0	11,665,226	256,353.00	45.50	4.00
5.00	Physical Therapists	532,633	0	532,633	14,806.00	35.97	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	427,921	0	427,921	11,729.00	36.48	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	447,840	0	447,840	12,451.00	35.97	11.00
12.00	Respiratory Therapists	6,707,120	0	6,707,120	152,883.00	43.87	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	0	0	0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	0	0	0	0.00	0.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	0	0	0	0.00	0.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	0	0	0	0.00	0.00	17.00
18.00	Physical Therapists	0	0	0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0	0	0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0	0	0	0.00	0.00	20.00
21.00	Occupational Therapists	0	0	0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0	0	0	0.00	0.00	23.00
24.00	Speech Therapists	0	0	0	0.00	0.00	24.00
25.00	Respiratory Therapists	0	0	0	0.00	0.00	25.00
26.00	Other Medical Staff	0	0	0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315289

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

Worksheet S-7

Date/Time Prepared:
5/26/2024 12:23 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. : 315289

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

Worksheet S-7

Date/Time Prepared:
5/26/2024 12:23 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. : 315289		Period: From 01/01/2023 To 12/31/2023		Worksheet A		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1,157,054	1,157,054	0	1,157,054	1.00
3.00	00300	EMPLOYEE BENEFITS	0	6,370,487	6,370,487	0	6,370,487	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	1,656,238	5,705,469	7,361,707	0	7,361,707	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	351,449	544,631	896,080	0	896,080	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	359,902	359,902	0	359,902	6.00
7.00	00700	HOUSEKEEPING	0	477,382	477,382	0	477,382	7.00
8.00	00800	DIETARY	77,185	1,043,849	1,121,034	0	1,121,034	8.00
9.00	00900	NURSING ADMINISTRATION	688,656	0	688,656	0	688,656	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	426,319	426,319	0	426,319	10.00
11.00	01100	PHARMACY	0	75,818	75,818	0	75,818	11.00
13.00	01300	SOCIAL SERVICE	179,759	44,558	224,317	0	224,317	13.00
15.00	01500	PATIENT ACTIVITIES	907,682	240,761	1,148,443	0	1,148,443	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	18,372,346	2,161,865	20,534,211	0	20,534,211	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	8,026	8,026	0	8,026	40.00
41.00	04100	LABORATORY	0	18,942	18,942	0	18,942	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	532,633	1,436	534,069	0	534,069	44.00
45.00	04500	OCCUPATIONAL THERAPY	427,921	5,716	433,637	0	433,637	45.00
46.00	04600	SPEECH PATHOLOGY	447,840	4,991	452,831	0	452,831	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	363,556	363,556	0	363,556	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	61,390	61,390	0	61,390	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	23,641,709	19,072,152	42,713,861	0	42,713,861	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00	09500	DAY CARE	1,021,758	362,357	1,384,115	0	1,384,115	95.00
100.00		TOTAL	24,663,467	19,434,509	44,097,976	0	44,097,976	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315289

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

Worksheet A
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-423,527	733,527	1.00
3.00	00300	EMPLOYEE BENEFITS	0	6,370,487	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-1,324,022	6,037,685	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	896,080	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	359,902	6.00
7.00	00700	HOUSEKEEPING	0	477,382	7.00
8.00	00800	DIETARY	0	1,121,034	8.00
9.00	00900	NURSING ADMINISTRATION	0	688,656	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	426,319	10.00
11.00	01100	PHARMACY	0	75,818	11.00
13.00	01300	SOCIAL SERVICE	0	224,317	13.00
15.00	01500	PATIENT ACTIVITIES	0	1,148,443	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	20,534,211	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	8,026	40.00
41.00	04100	LABORATORY	0	18,942	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	534,069	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	433,637	45.00
46.00	04600	SPEECH PATHOLOGY	0	452,831	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	363,556	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	61,390	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	52.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
72.00	07200	CORF	0	0	72.00
73.00	07300	CMHC	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	-1,747,549	40,966,312	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER & 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	DAY CARE	0	1,384,115	95.00
100.00		TOTAL	-1,747,549	42,350,427	100.00

Provider No. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/26/2024 12:23 pm
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		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. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/26/2024 12:23 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. : 315289

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

Worksheet A-7

Date/Time Prepared:
5/26/2024 12:23 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0	0	0	0	1.00
2.00 Land Improvements	148,784	0	0	0	0	2.00
3.00 Buildings and Fixtures	0	0	0	0	0	3.00
4.00 Building Improvements	465,402	0	0	0	0	4.00
5.00 Fixed Equipment	412,207	0	0	0	0	5.00
6.00 Movable Equipment	1,402,675	0	0	0	0	6.00
7.00 Subtotal (sum of lines 1-6)	2,429,068	0	0	0	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	2,429,068	0	0	0	0	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0				
2.00 Land Improvements	148,784	0				
3.00 Buildings and Fixtures	0	0				
4.00 Building Improvements	465,402	0				
5.00 Fixed Equipment	412,207	0				
6.00 Movable Equipment	1,402,675	0				
7.00 Subtotal (sum of lines 1-6)	2,429,068	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	2,429,068	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315289

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

Worksheet A-8

Date/Time Prepared:
5/26/2024 12:23 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line No.	
			Cost Center			
			1.00	2.00		
1.00 Investment income on restricted funds (chapter 2)	B	-157,412	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	-1,245,719				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals		0			0.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Vending machines		0			0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00	22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			0*** Cost Center Deleted ***		2.00	24.00
25.00 SPACE RENTAL	B	-207,253	CAP REL COSTS - BLDGS & FIXTURES		1.00	25.00
25.03 ADVERTISING / PUBLIC RELATIONS	A	-967	ADMINISTRATIVE & GENERAL		4.00	25.03
25.04 BAD DEBTS	A	-130,298	ADMINISTRATIVE & GENERAL		4.00	25.04
25.05 CONTRIBUTIONS POLITICAL	A	-5,900	ADMINISTRATIVE & GENERAL		4.00	25.05
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,747,549				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. : 315289

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/26/2024 12:23 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/LEASE EXPENSE	1.00
2.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	CAPITAL EXPENSE	2.00
3.00	4.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE EXPENSE	3.00
4.00	0.00			4.00
5.00	0.00			5.00
6.00	4.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE	6.00
7.00	51.00	SUPPORT SURFACES	SUPPORT SERVICES	7.00
8.00	0.00			8.00
9.00	0.00			9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00
	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
	4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	1,024,341	-1,024,341	1.00
2.00	965,479	0	965,479	2.00
3.00	51,138	0	51,138	3.00
4.00	0	0	0	4.00
5.00	0	0	0	5.00
6.00	1,315,889	2,553,884	-1,237,995	6.00
7.00	61,390	61,390	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
	2,393,896	3,639,615	-1,245,719	

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

Provider No. : 315289

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/26/2024 12:23 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	A	ANDREW WEI SMAN	0.00	1.00
2.00	A	ANDREW WEI SMAN	0.00	2.00
3.00	A	ANDREW WEI SMAN	0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00	A	ANDREW WEI SMAN	0.00	6.00
7.00	A	ANDREW WEI SMAN	0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00		VOORHEES PED CTR ASSOC	0.00	REAL ESTATE	1.00
2.00		VOORHEES PED CTR ASSOC	0.00	REAL ESTATE	2.00
3.00		VOORHEES PED CTR ASSOC	0.00	REAL ESTATE	3.00
4.00			0.00		4.00
5.00			0.00		5.00
6.00		CENTENNIAL HS	0.00	CONSULTING SER	6.00
7.00		HBA THERAPY	0.00	SPECIALTY MATTRESS	7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315289

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2024 12: 23 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	733,527	733,527			1.00
3.00 00300	EMPLOYEE BENEFITS	6,370,487	0	6,370,487		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	6,037,685	0	427,800	6,465,485	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	896,080	0	90,778	177,805	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	359,902	0	0	64,845	6.00
7.00 00700	HOUSEKEEPING	477,382	0	0	86,011	7.00
8.00 00800	DIETARY	1,121,034	0	19,937	205,572	8.00
9.00 00900	NURSING ADMINISTRATION	688,656	0	177,877	156,126	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	426,319	0	0	76,811	10.00
11.00 01100	PHARMACY	75,818	0	0	13,660	11.00
13.00 01300	SOCIAL SERVICE	224,317	0	46,431	48,781	13.00
15.00 01500	PATIENT ACTIVITIES	1,148,443	0	234,451	249,160	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	20,534,211	705,730	4,745,515	4,681,867	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	8,026	0	0	1,446	40.00
41.00 04100	LABORATORY	18,942	0	0	3,413	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	534,069	0	137,577	121,012	44.00
45.00 04500	OCCUPATIONAL THERAPY	433,637	0	110,530	98,044	45.00
46.00 04600	SPEECH PATHOLOGY	452,831	0	115,675	102,429	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	363,556	0	0	65,503	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	61,390	0	0	11,061	51.00
52.00 05200	OTHER ANCILLARY SERVICES	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICES	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	72.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	40,966,312	705,730	6,106,571	6,163,546	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS' LAUNDRY	0	0	0	0	94.00
95.00 09500	DAY CARE	1,384,115	27,797	263,916	301,939	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	42,350,427	733,527	6,370,487	6,465,485	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315289

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	1,164,663				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	424,747			6.00
7.00	00700	HOUSEKEEPING	0	0	563,393		7.00
8.00	00800	DIETARY	0	0	0	1,346,543	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	0	0	1,022,659
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	11.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	1,120,528	424,747	542,043	1,346,543	1,022,659
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	1,120,528	424,747	542,043	1,346,543	1,022,659
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	94.00
95.00	09500	DAY CARE	44,135	0	21,350	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	1,164,663	424,747	563,393	1,346,543	1,022,659

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315289

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
	10.00	11.00	13.00	15.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	503,130				10.00
11.00 01100	PHARMACY	0	89,478			11.00
13.00 01300	SOCIAL SERVICE	0	0	319,529		13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	1,632,054	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	503,130	89,478	319,529	1,632,054	37,668,034 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	9,472 40.00
41.00 04100	LABORATORY	0	0	0	0	22,355 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	792,658 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	642,211 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	670,935 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	429,059 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	72,451 51.00
52.00 05200	OTHER ANCILLARY SERVICES	0	0	0	0	0 52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC	0	0	0	0	0 62.00
63.00 06300	OTHER OUTPATIENT SERVICES	0	0	0	0	0 63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
72.00 07200	CORF	0	0	0	0	0 72.00
73.00 07300	CMHC	0	0	0	0	0 73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0 74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
84.00 08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0 84.00
89.00	SUBTOTALS (sum of lines 1-84)	503,130	89,478	319,529	1,632,054	40,307,175 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	0 91.00
92.00 09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS' LAUNDRY	0	0	0	0	0 94.00
95.00 09500	DAY CARE	0	0	0	0	2,043,252 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	503,130	89,478	319,529	1,632,054	42,350,427 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315289

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description		Post Stepdown Adjustments	Total	
		17.00	18.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	37,668,034	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF/IID	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	9,472	40.00
41.00	04100	LABORATORY	22,355	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	792,658	44.00
45.00	04500	OCCUPATIONAL THERAPY	642,211	45.00
46.00	04600	SPEECH PATHOLOGY	670,935	46.00
47.00	04700	ELECTROCARDIOLOGY	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	429,059	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100	SUPPORT SURFACES	72,451	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	52.00
OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FQHC	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	63.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
72.00	07200	CORF	0	72.00
73.00	07300	CMHC	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	74.00
SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	40,307,175	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	94.00
95.00	09500	DAY CARE	2,043,252	95.00
98.00		Cross Foot Adjustments	0	98.00
99.00		Negative Cost Centers	0	99.00
100.00		TOTAL	42,350,427	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315289

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES					
	0	1.00		2A	3.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	0	0	0	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00 00700	HOUSEKEEPING	0	0	0	0	0	7.00
8.00 00800	DIETARY	0	0	0	0	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
13.00 01300	SOCIAL SERVICE	0	0	0	0	0	13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	0	705,730	705,730	0	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
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICES	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	0	72.00
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW - SNF						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	705,730	705,730	0	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00 09500	DAY CARE	0	27,797	27,797	0	0	95.00
98.00	Cross Foot Adjustments			0			98.00
99.00	Negative Cost Centers			0			99.00
100.00	TOTAL	0	733,527	733,527	0	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315289

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0			6.00
7.00	00700	HOUSEKEEPING	0	0	0		7.00
8.00	00800	DIETARY	0	0	0	0	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	11.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	0	0	0	0	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC					62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	0	0	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	94.00
95.00	09500	DAY CARE	0	0	0	0	95.00
98.00		Cross Foot Adjustments					98.00
99.00		Negative Cost Centers	0	0	0	0	99.00
100.00		TOTAL	0	0	0	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315289

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
	10.00	11.00	13.00	15.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0				10.00
11.00 01100	PHARMACY	0	0			11.00
13.00 01300	SOCIAL SERVICE	0	0	0		13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	0	0	705,730	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICES	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICES	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	72.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	0	0	705,730	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS' LAUNDRY	0	0	0	0	94.00
95.00 09500	DAY CARE	0	0	0	27,797	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	0	0	0	733,527	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315289

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description		Post Step-Down Adjustments	Total	
		17.00	18.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	705,730	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF/IID	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	40.00
41.00	04100	LABORATORY	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100	SUPPORT SURFACES	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	52.00
OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FQHC	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	63.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
72.00	07200	CORF	0	72.00
73.00	07300	CMHC	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	74.00
SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	705,730	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	94.00
95.00	09500	DAY CARE	27,797	95.00
98.00		Cross Foot Adjustments	0	98.00
99.00		Negative Cost Centers	0	99.00
100.00		TOTAL	733,527	100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315289

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

Worksheet B-1

Date/Time Prepared:
5/26/2024 12:23 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	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	56,525					1.00
3.00 00300	EMPLOYEE BENEFITS	0	24,663,467				3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	1,656,238	-6,465,485	35,884,942		4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	351,449	0	986,858	56,525	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	0	0	359,902	0	6.00
7.00 00700	HOUSEKEEPING	0	0	0	477,382	0	7.00
8.00 00800	DIETARY	0	77,185	0	1,140,971	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	688,656	0	866,533	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	426,319	0	10.00
11.00 01100	PHARMACY	0	0	0	75,818	0	11.00
13.00 01300	SOCIAL SERVICE	0	179,759	0	270,748	0	13.00
15.00 01500	PATIENT ACTIVITIES	0	907,682	0	1,382,894	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	54,383	18,372,346	0	25,985,456	54,383	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	8,026	0	40.00
41.00 04100	LABORATORY	0	0	0	18,942	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	532,633	0	671,646	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	427,921	0	544,167	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	447,840	0	568,506	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	363,556	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	61,390	0	51.00
52.00 05200	OTHER ANCILLARY SERVICES	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICES	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	0	72.00
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW - SNF						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	54,383	23,641,709	-6,465,485	34,209,114	54,383	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER & BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS' LAUNDRY	0	0	0	0	0	94.00
95.00 09500	DAY CARE	2,142	1,021,758	0	1,675,828	2,142	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)	733,527	6,370,487		6,465,485	1,164,663	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	12.977037	0.258296		0.180173	20.604387	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		0	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.000000	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315289

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

Worksheet B-1

Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	38,484				6.00
7.00	00700	HOUSEKEEPING	0	56,525			7.00
8.00	00800	DIETARY	0	0	38,484		8.00
9.00	00900	NURSING ADMINISTRATION	0	0	0	38,484	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	38,484
11.00	01100	PHARMACY	0	0	0	0	11.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	38,484	54,383	38,484	38,484	38,484
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	38,484	54,383	38,484	38,484	38,484
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER & BEAUTY SHOP	0	0	0	0	91.00
92.00	09200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	93.00
94.00	09400	PATIENTS' LAUNDRY	0	0	0	0	94.00
95.00	09500	DAY CARE	0	2,142	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)	424,747	563,393	1,346,543	1,022,659	503,130
103.00		Unit cost multiplier (Wkst. B, Part I)	11.036976	9.967147	34.989684	26.573615	13.073745
104.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	0
105.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315289

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

Worksheet B-1
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description	PHARMACY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (TOTAL PATIENT DAYS)	
	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
3.00 00300 EMPLOYEE BENEFITS				3.00
4.00 00400 ADMINISTRATIVE & GENERAL				4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 00600 LAUNDRY & LINEN SERVICE				6.00
7.00 00700 HOUSEKEEPING				7.00
8.00 00800 DIETARY				8.00
9.00 00900 NURSING ADMINISTRATION				9.00
10.00 01000 CENTRAL SERVICES & SUPPLY				10.00
11.00 01100 PHARMACY	38,484			11.00
13.00 01300 SOCIAL SERVICE	0	38,484		13.00
15.00 01500 PATIENT ACTIVITIES	0	0	38,484	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 SKILLED NURSING FACILITY	38,484	38,484	38,484	30.00
31.00 03100 NURSING FACILITY	0	0	0	31.00
32.00 03200 ICF/IID	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00 04000 RADIOLOGY	0	0	0	40.00
41.00 04100 LABORATORY	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	46.00
47.00 04700 ELECTROCARDIOLOGY	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	50.00
51.00 05100 SUPPORT SURFACES	0	0	0	51.00
52.00 05200 OTHER ANCILLARY SERVICES	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS				
60.00 06000 CLINIC		0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	0	61.00
62.00 06200 FOHC				62.00
63.00 06300 OTHER OUTPATIENT SERVICES	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS				
70.00 07000 HOME HEALTH AGENCY COST	0	0	0	70.00
71.00 07100 AMBULANCE	0	0	0	71.00
72.00 07200 CORF	0	0	0	72.00
73.00 07300 CMHC	0	0	0	73.00
74.00 07400 OTHER REIMBURSABLE COST	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS				
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00 08100 INTEREST EXPENSE				81.00
82.00 08200 UTILIZATION REVIEW - SNF				82.00
83.00 08300 HOSPICE	0	0	0	83.00
84.00 08400 OTHER SPECIAL PURPOSE COST	0	0	0	84.00
89.00 SUBTOTALS (sum of lines 1-84)	38,484	38,484	38,484	89.00
NONREIMBURSABLE COST CENTERS				
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00 09100 BARBER & BEAUTY SHOP	0	0	0	91.00
92.00 09200 PHYSICIANS' PRIVATE OFFICES	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	93.00
94.00 09400 PATIENTS' LAUNDRY	0	0	0	94.00
95.00 09500 DAY CARE	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)	89,478	319,529	1,632,054	102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	2.325070	8.302905	42.408637	103.00
104.00 Cost to be allocated (per Wkst. B, Part II)	0	0	0	104.00
105.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315289

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

Worksheet C
Date/Time Prepared:
5/26/2024 12:23 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	9,472	15,490	0.611491	40.00
41.00	04100	LABORATORY	22,355	37,186	0.601167	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	792,658	1,093,696	0.724752	44.00
45.00	04500	OCCUPATIONAL THERAPY	642,211	806,750	0.796047	45.00
46.00	04600	SPEECH PATHOLOGY	670,935	452,831	1.481645	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	429,059	677,278	0.633505	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	72,451	61,390	1.180176	51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0.000000	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FOHC				62.00
63.00	06300	OTHER OUTPATIENT SERVICES	0	0	0.000000	63.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	2,639,141	3,144,621		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/26/2024 12:23 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
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST						
ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADIOLOGY	0.611491	0	0	0	40.00
41.00	04100 LABORATORY	0.601167	0	0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	0.724752	0	0	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0.796047	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	1.481645	0	0	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0.633505	0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	1.180176	0	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICES	0.000000	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0.000000	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC					61.00
62.00	06200 FOHC					62.00
63.00	06300 OTHER OUTPATIENT SERVICES	0.000000	0	0	0	63.00
71.00	07100 AMBULANCE (2)	0.000000	0	0	0	71.00
100.00	Total (Sum of lines 40 - 71)		0	0	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. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/26/2024 12:23 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)	0.633505	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	0	3.00

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

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH							
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	9,472	0	0.000000	0	0 40.00
41.00	04100	LABORATORY	22,355	0	0.000000	0	0 41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0 43.00
44.00	04400	PHYSICAL THERAPY	792,658	0	0.000000	0	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	642,211	0	0.000000	0	0 45.00
46.00	04600	SPEECH PATHOLOGY	670,935	0	0.000000	0	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	429,059	0	0.000000	0	0 49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0 50.00
51.00	05100	SUPPORT SURFACES	72,451	0	0.000000	0	0 51.00
52.00	05200	OTHER ANCILLARY SERVICES	0	0	0.000000	0	0 52.00
100.00		Total (Sum of lines 40 - 52)	2,639,141	0		0	0 100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIIII		Provider No. : 315289	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/26/2024 12: 23 pm
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		0	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)		0	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinurance		0	5.00
6.00	Allowable bad debts (From your records)		0	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		0	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		0	11.00
12.00	Interim payments (See instructions)		0	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		0	14.75
14.99	Sequestration amount (see instructions)		0	14.99
15.00	Balance due provider/program (see Instructions)		0	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315289

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

Worksheet E-1

Date/Time Prepared:
5/26/2024 12:23 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		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		0		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor					8.00

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

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

Provider No. : 315289

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

Worksheet G

Date/Time Prepared:
5/26/2024 12:23 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	2,961,186	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	1,427,471	0	0	0	3.00
4.00	Accounts receivable	8,206,689	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	-339,728	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	356,389	0	0	0	8.00
9.00	Other current assets	-949,862	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	11,662,145	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	148,784	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	465,402	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	412,207	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	2,037,568	0	0	0	23.00
24.00	Less: Accumulated depreciation	-2,458,331	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	605,630	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	0	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	12,267,775	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,221,575	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,246,402	0	0	0	36.00
37.00	Payroll taxes payable	121,507	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2,589,484	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	417,909	0	0	0	48.00
49.00	OTHER	64,080	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	481,989	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	3,071,473	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,196,302	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	9,196,302	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	12,267,775	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315289

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

Worksheet G-1

Date/Time Prepared:
5/26/2024 12:23 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		2,216,594		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		6,979,708			2.00
3.00	Total (sum of line 1 and line 2)		9,196,302		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)		9,196,302		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)		9,196,302		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. : 315289

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/26/2024 12:23 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	96,066,174		96,066,174	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)	96,066,174		96,066,174	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	45,932,631	0	45,932,631	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
11.10	CORF		0	0	11.10
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)	141,998,805	0	141,998,805	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			44,097,976	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)			44,097,976	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315289

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

Worksheet G-3

Date/Time Prepared:
5/26/2024 12: 23 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	141,998,805	1.00
2.00	Less: contractual allowances and discounts on patients accounts	91,294,471	2.00
3.00	Net patient revenues (Line 1 minus line 2)	50,704,334	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	44,097,976	4.00
5.00	Net income from service to patients (Line 3 minus 4)	6,606,358	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	157,412	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	215,937	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	373,349	25.00
26.00	Total (Line 5 plus line 25)	6,979,707	26.00
27.00	OTHER	-1	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	-1	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	6,979,708	31.00